THE CANADIAN NURSE

UME 53 NUMBER 1
MONTREAL

Highlight for
ANUARY 1957

ACCREDITATION
SR. D. LEFEBVRE

•

NOW, I THINK . . .

•

(See page 4)

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THE CANADIAN NURSE
L'Infirmière Canadienne

VOLUME 53 **NUMBER 1**

JANUARY 1957

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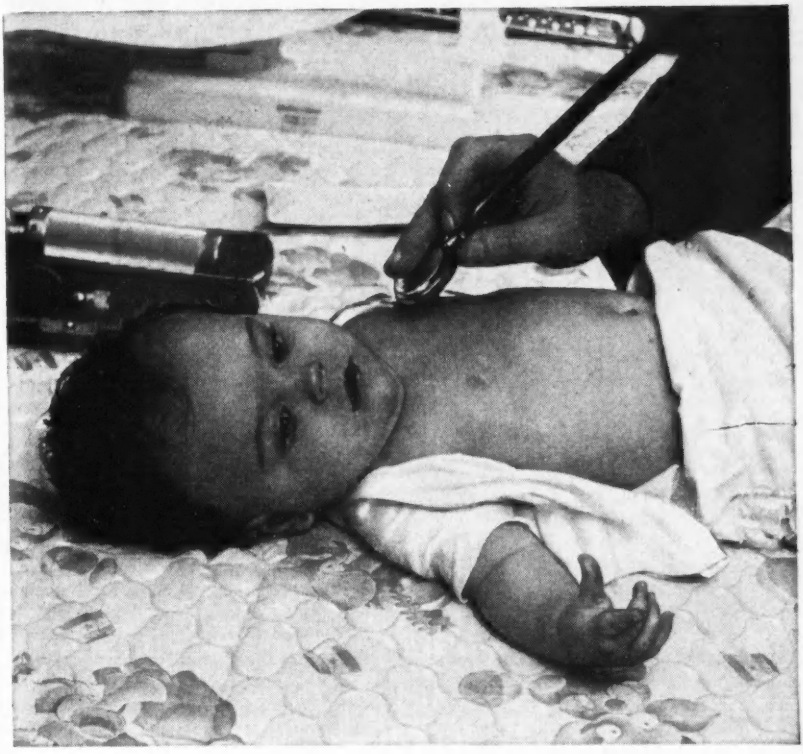

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Between Ourselves

The origin of some of our most familiar words may be traced to names that figure prominently in classical mythology. **January,** named for the Roman god Janus, is an interesting illustration.

Janus was one of the lesser gods but was nonetheless so powerful that his good will was invoked at the commencement of most actions. Even in the worship of the other gods, the votary began by offering wine and incense to Janus. He had charge of the gates of heaven and hence all other gates, including the gate to the new year, were supposed to be under his care. To enable him to keep a close watch at all of the gates, he was usually represented with two faces — one looking forward, the other backward.

In the original Roman calendar, the year began in March. Numa Pompilius is said to have added the month of Janus, giving it 30 days. When Julius Caesar reformed the calendar he appropriately made January the first month of the year and gave it an extra day, as we still have it.

* * *

It is appropriate that, in this the first issue for 1957, **Trenna Hunter,** president of the Canadian Nurses' Association, should pause briefly to look back on the past then, with her pen as substitute for Janus' staff, point out the road ahead. With so many projects underway in nursing in Canada, with the Pilot Study a new and far-reaching development, with the I.C.N. convention only a few months distant, 1957 promises to be a very busy year.

* * *

To most nurses in Canada, the question of the evaluation and accreditation of schools of nursing appears a very obscure topic. Not so to **Sister Denise Lefebvre!** Her interest in this proposition dates back for more than ten years to when she was called upon to play an exacting role in the evaluation program carried on by the Conference of Catholic Schools of Nursing, 1946-48. Since that time her knowledge and understanding of the issues involved have expanded tremendously until today she is considered our outstanding authority. She shares some of her enthusiasm for this development with both our English and French readers in the imaginary discussion between three enquiring nursing executives and a well informed fourth person.

* * *

This issue introduces a new feature which will, we hope, prove a valuable stimulus to nurses at every staff level and in every branch of our profession. "Nursing research" has a rather formidable sound until we stop to analyze just what it really means.

To assist our understanding of the possibilities of such a section and, we hope, to spur nurses to write their stories for publication, the Editorial Board of *The Canadian Nurse* asked **Rae Chittick** to prepare the initial outline of what is wanted. Miss Chittick and **Moyra Allen** have given us convincing evidence that the kind of material we want to receive is right at the finger tips of dozens of nurses. Won't you share with others through a continuing supply of interesting factual material?

* * *

Last Fall, there was a gala celebration in Saint John, N.B. when the Registered Nurses' Association passed its 40th birthday. **Jean MacGregor** represented *The Canadian Nurse* on that occasion and her report shares the stimulation of the sessions with you. Nor should you fail to read **Rae Chittick's** vitally interesting address given at the banquet. In fact, any of you who may be invited to give talks on nursing will find it a veritable storehouse of valuable speaking material.

* * *

Volume 53 is herewith well and truly launched. Any nurses wishing copies of the **Index** for 1956 are again reminded to send along the application form very soon.

* * *

The adorable twins on our cover are **David** on the left, **Robert** on the right, infant sons of Mr. and Mrs. D. Ross Bronson of Brampton, Ont. Three months of age when the picture was taken, their mother decided to prop them up on pillows for this shot.

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Edited by **DEAN F. N. HUGHES**

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Administration—In mild capillary bleeding states, 3 to 6 capsules daily, in divided doses. In acute bleeding or threatened abortion, and in virus infections, 9 to 12 capsules daily.

CORNEOMENT

Manufacturer—Nordic Biochemicals Ltd., Montreal.

Description—A solution consisting of 0.1 hydrocortisone and .5% neomycin.

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Administration—By means of the pipette included in the package.

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Description—Each fluid ounce contains: Kaolin 87.5 gr. and pectin 4.4 gr. in a pleasant mint-flavored carminative base.

Indications—An adsorbent demulcent preparation for the treatment of diarrhea.

Administration—Adults: First dose 2 tablespoonfuls then 1 or 2 tablespoonfuls after each bowel movement until symptoms are relieved.

Children: 2 or more teaspoonfuls according to age at intervals as stated above.

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Manufacturer—Ayerst, McKenna & Harrison Ltd., Montreal.

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The Journal *presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.*

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RIDUPOIS

Manufacturer—Paul B. Elder Co., Bryan, Ohio. **Can. Dist.:** J. M. Marsan & Co. Ltd., Montreal.

Description—Each tablet contains: Thyroid 1/5 gr., dl/methamphetamine HCl 2.5 mg. thiamine hydrochloride 1.0 mg., riboflavin 0.5 mg., carboxymethyl-cellulose 4.0 gr.

Indications—In treatment of obesity; in treatment of mildly depressed basal metabolism as an adjunct in treatment of hypotensive conditions.

Administration—One or two tablets 3 times daily, preferably taken between meals with the final dosage several hours before bedtime to avoid disturbance of normal sleep.

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Manufacturer—Walker Laboratories, Inc., Mount Vernon, N.Y.; **Can. Dist.:** Anglo-French Drug Co. Ltd., Montreal.

Description—Each teaspoonful contains: Reserpine 0.100 mg., hyoscyamine sulfate 0.105 mg., atropine sulfate 0.020 mg., hyoscine hydrobromide 0.007 mg.

Indications—For the relief of gastrointestinal spasm, "nervous stomach", emotional diarrhea, and other anxiety-tension states exhibiting visceral spasm as a prominent physical symptom.

Administration—Average adult dose is one teaspoonful 3 times daily or as prescribed.

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Dosage—For adults a total dose of 6 to 8 grams (6-8 teaspoonfuls) in 2 to 4 divided doses; for children and infants ½ to 2 grams (½-2 teaspoonfuls) depending upon body weight, 2 to 4 times daily. The initial dose should be twice the amount of the subsequent doses. In severe cases higher daily doses should be given in 3 to 4 divided doses.

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Administration—(Dosage should be based strictly on individual requirements) Adults — 1 to 2 tablets 4 times daily. (If required, a total daily dosage up to 12 tablets may be taken with safety, although continuation of such dosage is seldom required, except possibly in severe asthmatic conditions.)

Children—Up to 2 years, 1 to 2 tablets daily.

From 2 to 5 years — 2 to 4 tablets daily.

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THE CANADIAN NURSE

L'Infirmière Canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 53 NUMBER 1

MONTREAL, JANUARY, 1957

Taking our Measure

As I WRITE THIS MESSAGE in November 1956, to be read in January 1957, we are passing through an anxious time in world affairs. Daily and nightly sessions of the United Nations Assembly and of our governments are being held and one listens with growing anxiety and puzzlement to the news. It is hard to turn one's thoughts to nursing affairs and to try to concentrate on our plans for the coming biennium, for before we are nurses, we are citizens and events are moving all too quickly for citizens of the world. However, we can only hope and pray that solutions will be found that will preserve world harmony.

In preparing for the Biennial Meeting in Winnipeg in June 1956, we went back to the writings of Mary Agnes Snively in *The Canadian Nurse* of July, 1908, and found in her address to the graduating class of the Training School for Nurses, General Hospital, Kingston, these words: "It is therefore your privilege and, I may add, your duty to be dedicated to the work thus far advanced and into the future open a better way." It was this thought — into the future open a better way — that we chose for the theme of the biennium 1956-58.

We have queried, as have others in allied professions, and as have our patients and the public, as to whether we have achieved a "better way" in

(Tony Archer, Vancouver)

TRENNA G. HUNTER

nursing. There are those who say we have not; who bemoan the loss of the good old-fashioned nurse who didn't mind doing a little housework and cooking along with her nursing; who say that the more education the nurse has, the less nursing she does; who say professional nurses are losing the human touch. One could, I truly believe, find just as much evidence to prove that there are thoughtful, skilled, educated and warmly human nurses today as in the past. I, for one, am cheered by the many events of the past few years that say we are approaching a better way.

The fact that for the first time a nurse, Miss Dorothy Percy, was included in the delegation from Canada attending the Technical Meeting of the Ninth World Health Assembly in Geneva at which the topic "Nurses: Their Education and Their Role in Health Programs" was discussed by nurses and doctors together was a signpost to a better way.

The fact that the excellent study on Nursing Education in New Brunswick, done by Dr. Kathleen Russell, was sponsored by the Provincial and Federal Governments and was conducted at the University of New Brunswick is surely another indication of the kind of support and interest we want to see developed in nursing matters. The fact that we now have six independent schools of nursing in Canada[1] — three of them established in 1955 — is surely a sign of progress.

The fact that nurses, by the very quality of their contributions, have increased the demand for their services to the point that everyone talks about shortage of nursing service, is another sign that is good. If no one wanted our services, and the supply was greater than the demand, then we would have cause for worry. The fact that experiments have been tried and are still going on in nursing education in Canada and that there is such widespread interest in searching for a better way is encouraging.

The fact that nurses from Canada are acceptable in all parts of the world and are making outstanding contributions in so many areas and in so many corners of the earth is good. All of these are signs of encouragement but there is still so much to accomplish that there is no place for smugness or self-satisfaction.

Lucille Petry Leone has said:

> Nurses themselves are the experts in nursing — but allowing a nurse time and money for basic research or significant writing is not generally accepted. Research and studies should be carried on by nurses with expert advice of other researchers.[2]

We are happy that at least one significant piece of research has been accomplished in the above manner — the Head Nurse Study[3] — but we need to do so much more. The nursing world is full of exciting research material if only we could get the time, the money and the nurses to carry on with studies.

You have read, in the reports of the Biennial Meeting in Winnipeg, that the general meeting approved a Pilot Study for the evaluation of schools of nursing in Canada, evaluation being the first step in accreditation of schools. Accreditation is defined as an analysis of the educational program of a school with a view to stating whether or not such a school is worthy of public recognition.

1. The Report of a Study of Nursing Education in New Brunswick, The Independent Schools of Nursing in Canada:
   The Atkinson School of Nursing, Toronto Western Hospital, Toronto. Established, 1950.
   The Queen Elizabeth Hospital School of Nursing, Montreal. Established in 1953.
   The Maisonneuve Hospital School of Nursing, Montreal. Established in 1954.
   The St. John's General Hospital School of Nursing, St. John's, Newfoundland. Established in 1955.
   The Grace Hospital School of Nursing, St. John's, Newfoundland. Established in 1955.
   The Metropolitan Hospital School of Nursing, Windsor, Ontario. Established in 1955.

2. *Public Health Nursing*, August 1948, Community Needs for Nursing Care.

3. A Study of the Functions and Activities of Head Nurses in a General Hospital, Department of National Health and Welfare, Ottawa.

What you may not know is that in the same city of Winnipeg in the same setting — the general meeting in 1944 — a panel of members recommended accreditation as one means of assisting schools of nursing to obtain their objective of preparing nurses to meet the needs of Canadian people. Twelve years have elapsed before that recommendation is being, we hope, put into effect. They were not twelve wasted years, however. The idea has been kept before the general membership and the executive through articles in *The Canadian Nurse*, by a workshop on the subject in 1950, by the Canadian Conference of Catholic Schools of Nursing's intensive study of evaluation methods. We feel that our members are better informed and more ready to launch a program of accreditation than they might have been twelve years ago.

Not only should we continue our efforts to have better prepared people among the nurses presently engaged in nursing, through increased bursaries and scholarships, but we must redouble our efforts to recruit more students to the nursing field — the competition among the professions and industry is very keen and every profession wants its share of the graduates from high schools. Information from the 1951 census shows that graduate nurses represent 3 per cent of all female employees, practical nurses 1.6 per cent. In other words, every eighteenth woman working is employed in one of the above categories. In 1954, 10 per cent of the girls graduating from high schools entered nursing. Is nursing competing successfully for its share of high school graduates?

Shortage of nurses has become a byword and yet we know that in Canada we are well off in comparison to some other countries. Distribution is our problem and in many areas the shortage is immediate and urgent. As an example, although there are more patients in our mental hospitals than in our public general hospitals, only 2.3 per cent of the total number of registered nurses in Canada are employed in mental hospitals. Our association is concerning itself with this kind of problem.

One cannot in this short message begin to cover all the areas of interest that the Canadian Nurses' Association has been or will be concerned with. One can only hope that we will act as George Bernard Shaw's tailor. George Bernard Shaw had this to say about him:

> The only man who behaves sensibly is my tailor; he takes my measure anew every time he sees me, while all others go on with their old measurements and expect them to fit me.

I hope that in this New Year, 1957 we, as members of the Canadian Nurses' Association, will all take our measure anew.

TRENNA G. HUNTER
President
Canadian Nurses' Association

The work never gets all done up. The new day brings its troop of new duties. We can never sit down and feel that all the burdens have fallen from us. Sometimes we get tired of that, but there is quite another side to the matter. If the work never all gets past us, neither do the opportunities; if there are new duties every day so are there new hopes and new ambitions. Or at least there ought to be. There is no reason in the world why a man should not keep on doing new things, attacking new propositions, dreaming new dreams, right up till he is one hundred years old at least. Most of us would easily live that long if we filled up every day with the elixir of something new and fresh and stimulating. But we so easily let ourselves get dull and self-centred and unambitious, and settle down as if there were no fresh opportunities left. But there are, many of them.

— W. B. CREIGHTON

A hospital record is like a will in that, many times, it will be read and an attempt made to interpret the statements therein, when the original writer is not present. Each statement in the record, therefore, should be written with the thought in mind — can someone else, not familiar with this case, read this statement and know exactly what the writer meant to say.

— ROBERT P. MACFATE

What is Accreditation?

SISTER DENISE LEFEBVRE, S.G.M., M.Sc.N.Ed., D.Ed.

THE PANEL ON ACCREDITATION at the Canadian Nurses' Association biennial meeting in Winnipeg has left many questions in the minds of nurses concerning the proposed project. To assist in clarifying our thinking on what is meant by accreditation of our Canadian schools of nursing let us follow an imaginary discussion between four vitally interested nurses — one of whom is well-informed and answers the eager questions.

A. At the last biennial meeting of the Canadian Nurses' Association in Winnipeg a project to accredit the schools of nursing in Canada was presented to the general membership. I would like to know a little more about it and I am wondering what the term "accreditation," which they used, really means. It was explained, but I must admit it was all so new to me . . .

B. I would define the term accreditation as the official recognition of an institution by an authorized body. In professional organizations, accreditation is usually the responsibility of the profession concerned. It is a seal of approval placed upon a school, after a careful analysis and evaluation of its program. It becomes, therefore, a proof that the educational program carried on is worthy of public recognition.

SISTER DENISE LEFEBVRE

C. But, are not our provincial nurses' associations already doing this, through their periodic inspection of schools which, I understand, is compulsory by law?

B. No, not exactly, because approval or certification of schools by provincial nurses' associations indicates legal acceptance. It is coercive and has for its aim the control of professional practice. Minimum standards only can be strictly required, although many provincial associations suggest optimum achievement.

On the other hand, a national program of accreditation can maintain higher standards. It aims to help schools achieve a greater degree of perfection in their educational endeavor. It creates a certain stimulation for schools to know that they are meeting nationally approved standards which are not dependent upon local legislature but have been decided upon by the profession itself. Better uniformity of preparation for the same profession is thus achieved and, we hope, it would facilitate reciprocity between provinces.

Such a program is never compulsory; it can be more objective and help overcome local obstacles.

C. This appeals to me. In this way our school could voluntarily apply for accreditation and then be compared with other schools in Canada, not only those of our own province.

D. Although I am most happy to live in this democratic age, I am wondering what success a voluntary program would have?

B. If a program of accreditation is so organized as to help a school achieve its purposes and improve its program, I think that it would be well accepted. Any educational institution worthy of the name is eager to revise its methods and

Sister Lefebvre is Director of Nursing Education, Institute Marguerite d'Youville, Montreal.

review its objectives periodically.

We know that hospital accreditation is not compulsory, but the hospitals wishing to acquire status willingly request a survey in order to be accredited.

D. Then, I would say that public opinion would make such a program almost compulsory, if the schools concerned wish to survive.

A. I do think it might affect recruitment to a certain extent, although schools not nationally accredited could still be certified provincially, if they met at least minimum requirements. Provincial approval will always be necessary.

C. In the definition of accreditation the term was said to mean a "seal of approval" placed upon a school. Do I understand that public recognition is the only objective of an accreditation program?

B. No. All professional programs of accreditation have also in view the progress and improvement of the schools and they provide the necessary means of guidance to that end.

A. I think this is clarifying my thoughts on the subject, but there is one other question on my mind: how can national standards be enforced or applied to schools when all our systems of education, including nursing, are and should be under provincial jurisdiction?

B. Of course, no national standards could be enforced provincially and as I mentioned previously, provincial approval will always be essential. As for your second statement concerning the possibility of applying national standards to individual schools, I believe it can be done if the fundamental principle of sound, modern accreditation is respected in the planning of the program. The principle reads as follows:

> Each school is judged on the value of its objectives and the sincerity which it manifests in the pursuit of these objectives.

In such a program, individuality of institutions is recognized and promoted.

C. This appears to me much broader and more progressive than the adherence to a fixed pattern. A standardized program could never be imposed upon an institution. It would limit action and encourage schools to aim at a fixed set of practices for fear they might not attain the desired accreditation or, having attained it, might lose it. So, they might not do anything else but keep it!

D. I quiver at the thought of having to meet pre-determined, stiff standards. If I am doing a good piece of work why should I do it in exactly the same way as my neighbor? Initiative in education is so essential!

A. Then, am I right in thinking that if the purposes of our school are sound, educationally and professionally, and if we take all the means possible to realize them in practice, we can be reasonably sure of accreditation? I am becoming quite enthusiastic and would like to begin the review of our objectives now, to see whether or not they would be acceptable. Then, we could study how well we are achieving them in the carrying out of our program.

B. This reaction is quite normal and is one of the expected results of a plan for accreditation. There is no attempt on the part of the accrediting body to control institutions, but rather to stimulate them to self-evaluation.

D. Self-evaluation . . . the word is modern and challenging! I think our faculty members would be willing to undertake a study of that kind among themselves before they invite someone from outside.

A. I see many advantages to an evaluation, preceding accreditation. This could be carried out by the school faculty first and then, by a qualified nurse. The faculty would be highly motivated and would work better as a group toward a common goal — that of achieving recognition. And, then, when the time comes for participation in an accreditation program no one would be taken by surprise. I am sure better cooperation would result.

B. Self-evaluation requires a self-survey by all concerned: school faculty, hospital personnel, etc. Through this work in common, interpretation of the school's purposes and pro-

gram can be better achieved. This appreciation will normally lead to the desire to meet objectives and to secure the necessary means to that effect, which, in many instances, seemed impossible before: budget, personnel, equipment.

A. I can see our own members working for a period of months under the stimulus of such motivation and they would, because of this, accomplish a great deal in a short time. And I know, too, that they would derive much satisfaction in this participation.

B. An objective look, by the faculty, at the requirements, difficulties and successes of the educational program should constitute a very interesting and productive group study, which will show up in improved educational results.

C. Then, it would seem that accreditation of schools would improve nursing education.

B. It is not merely accreditation in itself that will effect improvements, but rather the awareness of the faculty as to present educational and nursing needs and their own common efforts to make the necessary changes. An accreditation program is only a means of stimulation towards the attainment of a desired end.

D. I might agree with this, but I am not so sure whether accreditation will improve nursing service . . .

B. Nursing education today must necessarily be shaped to meet the needs of the nursing service of tomorrow. This is the challenge placed before nursing educators and nursing service leaders at this time. They should work jointly, so that educational programs may be sound and produce nurses who will be able to do a great deal to bring about better nursing care. Standards and norms in nursing education have no valid reason for existence except in the interests of the care of the sick.

C. Some mention was made earlier to accreditation of hospitals, I know this is accomplished through a joint commission, which carries out its work in both the United States and Canada. Before we had our hospital approved, we studied the requirements. It was most stimulating. Are there other agencies or organizations in Canada using accrediting services?

B. There are many institutions now using accrediting services. It was my privilege to visit a few and to consult with the persons responsible for their organization and functioning. In our investigation, we learned that among the five Canadian professional organizations visited, only one, the Canadian Dental Association, had a completely Canadian program. The four others were participating or sharing in American programs.

C. My brother, who is a dentist told me about this program. It started in 1948 and was accomplished gradually. First, the Council on Dental Education published a brochure entitled "Requirements for the Approval of a Dental School." This helped to improve the five Canadian dental faculties. Then an initial survey for evaluation was made in 1950 followed by a period for consultation and re-visiting. It was only in 1953 that the Dental Schools were accredited, after a visit and an analysis of their programs.

A. This is so stimulating! I would also like to hear about the other organizations.

B. Accrediting of Canadian Schools of Social Work is done through the Council on Social Work Education of New York City. The criteria used as a basis for accreditation are the same as those applied to American schools. Fees are also the same. Application is made by individual institutions.

The Canadian Library Association has no program of accreditation of its own, but there is a movement within the Association to study the possibility of organizing such a program. At present, the schools are accredited by the American Library Association. The obstacle to a Canadian program, at this time, seems to be the lack of the necessary funds.

D. What about Medical Schools?

B. The Canadian Medical Association does not undertake accreditation either. Medical schools in the

United States and Canada, are rated by the Council on Medical Education and Hospitals of the American Medical Association and the Executive Council of the American Medical Colleges. Schools are evaluated by liaison survey teams representing the two Councils.

C. This is most interesting. In searching *The Canadian Nurse* for more information about evaluation and accreditation, I found an article describing the work of the Conference of Catholic Schools of Nursing in that respect. Are they continuing their program?

B. This conference constitutes the Committee on Education of the Catholic Hospital Association of Canada. From 1946 to 1948, the Conference visited and evaluated 24 schools throughout Canada. The results were published in *The Canadian Nurse* (April 1950, pp. 278-285). The project was financed by the Catholic Hospital Association of the United States and Canada, and the evaluation was done with the help of their experienced personnel. It was a pioneer work in Canada which is worthy of recognition.

At the present time, the Conference is studying the possibility of continuing the program but nothing is as yet official. The method is presently under discussion and we think the adopted formula will provide a program of counselling and guidance from which the Catholic schools will benefit freely. The Conference is also interested in the Canadian Nurses' Association's program.

D. You also have something to tell us about some of the American organizations for accreditation?

B. We also had the privilege of visiting several American organizations among which were the North Central Association of Colleges and Secondary Schools, the Conference of Catholic Schools of Nursing and the National League for Nursing.

The secretary of the North Central Association gave us valuable material on various phases of their program — one of the oldest and the one on which most Accrediting Services have been modeled.

The Association carries both guidance and inspection services. National committees are set up to help in counselling, while district committees assist institutions when necessary. They also have consultants going to schools on request. This latter service is extended to non-accredited schools. Visitors are recruited from various professional interests and are mostly from the field.

There is no temporary accreditation; those schools not accredited are placed on a list as subject to re-visiting. Once accredited a re-evaluation is made only when deemed necessary; there is a questionnaire which keeps the Association up-to-date as to the status of the institution.

Before being visited, the school is asked to make a self-survey which should be a comprehensive and intensive study of its program by the faculty. The visitors do not evaluate on the basis of fixed standards, they rather look for intellectual vitality. The criteria used were set up by a committee of experts and adopted by the Association; they are revised periodically. The representative we met spoke highly about the value of self-evaluation and of a system of improvement through counselling and guidance.

Another well known accrediting body in the United States is the National League for Nursing. To explain in a few words their program of accreditation is an impossible task. A very elaborate plan of accreditation as well as education and guidance has been initiated on a national scale. During the past years they have developed schedules, criteria and a technique. They have also published a variety of material on the subject. The official accreditation service is functioning under the direction of the Education division of the National League for Nursing. Upon request, officially appointed visitors survey the schools. A report is presented to a central Committee and a decision is taken for or against the accreditation of the school, according to the report given by the visitors.

They also have a Counselling

program for the needs of nursing schools, either by means of a special visitor or consultant, or by means of publications.

A visit of accreditation costs between $500 to $800 to each school. An institutional annual fee of about $200 is paid by the member-schools that wish to provide for themselves the benefits of the guidance program.

A. I did not expect my first question to develop into a real forum on accreditation. May we come back to Canada now? I would like to have more definite information concerning the plans of the Canadian Nurses' Association.

B. The Canadian Nurses' Association is firm in its conviction that it is the responsibility of a profession to evaluate its own programs of education and have decided to begin by a Pilot Study on evaluation.

D. I suppose this first study would be done to determine the present status of our schools of nursing.

C. I would rather consider it as a first step or, perhaps, an experiment from which a program could develop.

B. The purposes of the Pilot Study have been defined by a special committee and formulated as follows:

To determine whether Canadian schools of nursing are ready for a program of accreditation and if it is feasible at this time to initiate such a program.

To determine the bases on which schools of nursing in Canada can be accredited.

To explore procedures in carrying out an accreditation program.

To determine the personnel and other resources needed to carry out a national program.

To estimate the cost of a national program of accreditation.

To acquaint the Canadian people with the needs of nursing.

A. These objectives are quite comprehensive. Please tell us how this will be carried out.

B. Because of the wide experience of the National League for Nursing over a period of 20 years, during which time they have developed techniques and facilities, the Executive Committee of the Canadian Nurses' Association decided to invite one of their representatives to carry out the study with the assistance of the CNA. It appears, however, that this original plan will be modified and rather than American nurses coming to Canada, Canadian nurses will spend a period of observation at the National League for Nursing, upon the latter's kind invitation.

D. American nurses are always so willing to help!

C. Then, will these Canadian observers carry on the pilot study, when they return?

B. We do not know exactly yet what procedure will be adopted. A committee on the Pilot Study for Evaluation of Schools of Nursing has been set up to follow the developments of the project and to make recommendations to the Executive of the Canadian Nurses' Association. It seems logical, that these nurses will participate very actively in the study. Moreover, each provincial nurses' association will be requested to recommend suitable and well qualified nurses willing to act as regional visitors. From the names submitted there will be set up a selective panel of visitors who will participate in the pilot study.

C. I am most eager to know how the schools will be selected for the pilot study. Will all schools have an equal opportunity?

B. The procedure for the selection of schools is as follows:

Each provincial nurses' association will be requested to acquaint all schools of nursing in the province with the nature of the project and invite them to signify willingness to participate, if selected.

From the list submitted by the provincial nurses' associations there will be selected by the Committee not less than 20 schools, with at least one school from each province. It is expected that the selection will take into consideration such factors as: the size of the school, type of control, location, etc., so that the study will represent a cross-section of diploma programs in nursing education.

A. This has been a most challenging discussion! I am sorry that we

must part now, but next time, we will have to solve some of the problems today's discussion has caused to develop in my own mind. May I name a few?

What personnel will be required to carry out the proposed plan?

When an accreditation program is set up, will we have a Canadian program or are we going to share with the American service, like some other organizations do at the present time?

What will be the criteria upon which schools will be judged?

Will faculties of schools of nursing have something to say in determining requirements for accreditation?

What will it cost and where will the Association find the money?

D. These are all practical questions, especially the last one! Let us meet again soon.

Qu'est-ce que l'Accréditation?

SOEUR DENISE LEFEBVRE, S.G.M., M.Sc.Ed.Inf., D.Péd.

LE FORUM sur l'accréditation tenu à Winnipeg lors de la réunion bi-annuelle de l'Association des Infirmières canadiennes a suscité, dans l'esprit des infirmières, une foule de points d'interrogation concernant le projet présenté. Cette causerie se propose de répondre à quelques-unes de ces questions sur le but de l'accréditation des écoles d'infirmières. Participantes: Quatre infirmières vivement intéressées aux initiatives dans le domaine professionnel.

A. Lors du Congrès bi-annuel de l'Association des infirmières canadiennes à Winnipeg, on a présenté un projet en vue d'accréditer les écoles d'infirmières au Canada. Je me demande ce que le terme "accréditation" veut dire exactement? On l'a expliqué alors, mais je dois avouer que tout cela est bien nouveau pour moi.

B. L'accréditation est la reconnaissance officielle d'une institution par un corps autorisé. Dans les organisations professionnelles, cette responsabilité relève habituellement de la profession concernée. C'est un sceau, un cachet d'approbation accordé à l'école, à la suite d'une analyse minutieuse et de l'évaluation de son programme. Elle devient donc une preuve que le système éducatif en usage est digne d'une reconnaissance publique.

C. Mais, nos associations provinciales d'infirmières n'accomplissent-elles pas justement cette fonction au moyen de leur inspection périodique des écoles, que la loi rend obligatoire, je crois?

B. Oui, vous avez raison. L'approbation ou la certification des écoles par l'association provinciale des infirmières indique une acceptation légale. Elle est obligatoire et a pour but de contrôler la pratique professionnelle. Cependant, seuls, des standards minima peuvent être strictement requis, même si certaines associations provinciales suggèrent un rendement optimum.

Un programme national d'accréditation présente des standards plus élevés et permet d'aider les écoles à progresser. C'est un stimulant pour une institution de savoir qu'elle rencontre des standards nationaux qui ne dépendent pas de la législation locale, mais qui sont déterminés par la profession elle-même. Une plus grande uniformité de préparation pour la même profession peut être obtenue et, nous l'espérons, une plus facile réciprocité entre les provinces.

Un tel programme n'est jamais obligatoire; il peut donc être plus objectif et devenir un moyen de vaincre certains obstacles locaux.

C. Ceci me plaît beaucoup. De cette façon, notre école pourrait librement faire application pour l'accréditation et ensuite être comparée,

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non seulement avec les écoles de la province, mais avec celles de tout le Canada.

D. Même si j'apprécie le privilège de vivre dans cet âge démocratique, je me demande quel succès peut bien avoir un programme facultatif.

B. Si un programme d'accréditation est organisé de façon à fournir l'aide nécessaire à une école, lui permettant ainsi d'atteindre ses objectifs et d'améliorer son programme, je pense qu'il sera bien accepté. Toute institution digne de ce nom éprouve le besoin de reviser ses méthodes et de revoir ses buts périodiquement. Nous savons que l'accréditation des hôpitaux n'est pas obligatoire; néanmoins, tout hôpital qui désire être bien coté réclame de bon gré un examen, afin d'être accrédité.

D. Alors, je conclus que l'opinion publique rend un tel programme presque obligatoire, si les écoles concernées désirent survivre.

A. Je pense, en effet, que le recrutement en serait affecté jusqu'à un certain point, quoique les écoles sans accréditation nationale peuvent être certifiées par leur province, à condition qu'elles répondent au moins aux exigences minima. L'approbation provinciale sera toujours nécessaire.

C. On définit l'accréditation comme un sceau d'approbation accordé à une école. Devons-nous conclure que la reconnaissance publique est le seul but du programme d'accréditation?

B. Non. Tous les programmes professionnels d'accréditation ont aussi en vue le progrès et l'amélioration des écoles et fournissent les moyens nécessaires à cet effet.

A. Tout cela m'éclaire sur le sujet, mais une autre question se pose à mon esprit: Comment des standards nationaux peuvent-ils être appliqués ou imposés aux écoles, alors que tous nos systèmes d'éducation, même le nursing, sont et doivent demeurer, sous la juridiction provinciale?

B. Evidemment, comme je vous le disais tout à l'heure, aucun standard national ne peut être imposé aux provinces et il sera toujours essentiel pour les écoles d'obtenir l'approbation provinciale.

En ce qui concerne la possibilité d'appliquer des standards nationaux aux écoles en particulier, je ne crois la chose justifiable qu'à la condition d'établir un système qui réponde aux besoins des temps et qui respecte, dans son programme, le principe fondamental de toute accréditation solide et vraiment fructueuse. Ce principe se lit comme suit:

Chaque école est jugée d'après la valeur de ses objectifs et sur la sincérité et la compétence manifestées dans la poursuite de ces mêmes objectifs.

Avec un tel programme, l'individualité des institutions est sauvegardée et encouragée.

C. Ceci montre beaucoup de largeur de vues et me semble plus progressif qu'un système qui exige l'adhésion aveugle à un plan rigide. Une école qui veut aller de l'avant ne peut se voir imposer un programme standardisé. Cela paralyserait son action et l'exposerait au danger de limiter ses efforts à la seule obtention de l'accréditation et, une fois celle-ci obtenue, à faire en sorte de la maintenir, sans plus.

D. Je ne puis m'arrêter à la pensée de m'en tenir à des standards rigides, déterminés à l'avance. Si j'accomplis un travail louable et que les résultats attestent le succès obtenu, pourquoi devrais-je être forcée d'adopter d'autres méthodes parce qu'on me les impose? L'initiative en éducation est tellement essentielle!

A. Alors, ai-je raison de croire que si les buts de notre école sont solidement éducatifs et professionnels et si nous prenons tous les moyens possibles pour les réaliser en pratique, l'accréditation de notre école est assurée? Je me sens remplie d'enthousiasme et j'aimerais commencer dès maintenant une étude de nos objectifs pour me rendre compte de leur valeur; ensuite nous pourrions voir comment nous les mettons en pratique.

B. Cette réaction est assez normale et c'est une conséquence prévue dans un plan d'accréditation. Ce dernier ne doit pas viser à contrôler les institutions, mais bien à les stimuler à une évaluation personnelle.

D. Evaluation personnelle . . . l'expression est moderne et peut devenir une aventure intéressante. Je pense que notre personnel enseignant serait prêt à commencer une étude de cette sorte, avant d'inviter quelqu'un de l'extérieur.

A. Je vois plusieurs avantages dans un programme d'évaluation précédant l'accréditation; la faculté de l'école prendrait d'abord l'initiative, et serait ainsi très fortement motivée par des efforts communs dirigés vers un but déterminé. Lorsque viendrait le moment de participer à un programme d'accréditation, on ne se sentirait pas pris au dépourvu et une meilleure coopération serait assurée.

B. Une évaluation personnelle exige une enquête sur place entreprise par toutes les personnes intéressées. Cette analyse en commun permet une meilleure compréhension, par tous, du programme et des buts de l'école. Une telle appréciation conduit normalement au désir de rencontrer les objectifs prévus et d'y employer tous les moyens nécessaires: budget, matériel, personnel.

A. Je prévois que nos institutrices travailleraient pour des mois sous le stimulant d'une telle motivation et qu'elles accompliraient ainsi beaucoup en peu de temps. Et je suis sûre qu'une grande satisfaction résulterait d'une telle participation.

B. Ce regard objectif de la faculté sur les exigences, les difficultés et les succès du programme de l'école devrait fournir le sujet d'une étude de groupe des plus intéressantes et des plus efficaces qui se manifesterait par de meilleurs résultats éducatifs.

D. Alors, il semble que, par l'accréditation, on améliorerait l'éducation des infirmières.

B. Ce n'est pas tellement l'accréditation en elle-même qui amènerait des améliorations, mais bien la prise de conscience par le corps enseignant des besoins du nursing moderne et ses efforts communs en vue d'effectuer les changements jugés nécessaires. Un programme d'accréditation n'est qu'un moyen de stimuler vers la réalisation du but convoité.

D. J'accepte volontiers ce que vous venez de dire, mais je n'ose me prononcer sur les améliorations qu'un tel programme peut apporter au soin des malades.

B. L'éducation des infirmières d'aujourd'hui doit se proposer comme but de répondre aux besoins du nursing de demain. Voilà le dilemne devant lequel sont placés les éducatrices d'infirmières et les chefs du service du nursing. Ces personnes devraient conjuguer leurs recherches et leurs efforts afin que les programmes soient solides et agencés de manière à promouvoir la formation d'infirmières compétentes qui sauront, dans l'avenir, fournir leur apport dans l'amélioration de tous les services et du nursing.

N'est-il pas vrai que les standards et les normes d'éducation n'ont de justification que s'ils servent les intérêts des malades, objet de la profession de l'infirmière?

C. On a fait mention, au début, de l'accréditation des hôpitaux, je sais qu'une Commission Conjointe est responsable de ce travail aux Etats-Unis et au Canada. Avant l'approbation de notre hôpital, nous en avons étudié les exigences. Y a-t-il d'autres organisations ou agences au Canada qui s'occupent d'accréditation?

B. Il y a présentement plusieurs organisations qui possèdent un programme d'accréditation. J'ai eu le privilège d'en visiter quelques-unes et de discuter avec les personnes responsables de leur fonctionnement.

Au cours de nos investigations, il fut intéressant de constater que, parmi les cinq organisations professionnelles visitées, une seule, l'Association Dentaire, possède un plan complètement canadien, les quatre autres participent à un programme américain .

D. Un ami dentiste m'a parlé de ce programme, qui à débuté en 1948 et fut complété graduellement. D'abord, le Conseil d'éducation dentaire publia une brochure intitulée "Exigences pour l'approbation d'une école dentaire." Cette publication contribua grandement à l'amélioration des cinq facultés dentaires canadiennes. Ensuite, un

examen initial fut entrepris en 1950, suivi d'une période de consultations et de nouvelles visites. Ce n'est qu'en 1953 que les Ecoles dentaires furent accréditées après une analyse et une évaluation complète de leur programme.

A. C'est merveilleux! Je voudrais entendre parler aussi des autres organisations.

B. L'accréditation des écoles de Service Social est accomplie par le Conseil de l'éducation en Service Social de New York. Les critères employés comme base de l'accréditation des écoles canadiennes sont les mêmes que pour les institutions américaines. Les déboursés sont aussi identiques, soit: les frais de voyage et de pension des deux ou trois visiteurs, plus $25.00 au Conseil. Chaque école place elle-même son application.

L'Association canadienne des Bibliothécaires ne possède pas son propre système d'accréditation; on étudie actuellement la possibilité d'organiser un tel programme au sein de l'association. Présentement, les écoles sont accréditées par lAssociation américaine des Bibiliothécaires. L'obstacle qui empêche, dans le moment, la réalisation d'un plan canadien semble être l'insuffisance des fonds disponibles.

D. Et les écoles de médecine?

B. L'Association Médicale canadienne n'accrédite pas les écoles. Les écoles de médecine du continent nord-américain, c'est-à-dire des Etats-Unis et du Canada, sont évaluées par le Conseil de l'Education médicale et des Hôpitaux de l'Association médicale américaine et le Conseil exécutif du Collège Médical américain. Les écoles sont évaluées par une équipe de visiteurs représentant les deux Conseils.

C. Ceci est des plus intéressants! En feuilletant *L'Infirmière canadienne* dans le but de me renseigner sur l'évaluation et l'accréditation, j'ai trouvé un article décrivant le travail de la Conférence Canadienne des Ecoles Catholiques d'Infirmières. Savez-vous si le programme se continue?

B. La Conférence Canadienne des Ecoles Catholiques d'Infirmières constitue le Comité d'éducation de l'Association des Hôpitaux catholiques du Canada. De 1946 à 1948, la Conférence a visité et évalué 24 écoles à travers le pays. Les résultats furent publiés dans *L'Infirmière canadienne,* (Avril 1950, pp. 278-285).

Le projet a été financé par l'Association des Hôpitaux catholiques des Etats-Unis et du Canada et l'évaluation accomplie avec l'aide de leur personnel expérimente. Ce fut un travail de pionnier au Canada et il mérite notre admiration.

Dans le moment, la Conférence étudie la possibilité de continuer le programme, mais rien n'est encore officiel. La méthode est présentement a l'etude et nous pensons que la formule adoptée établira un programme de consultation et d'aide dont les écoles catholiques bénéficieront à leur gré.

La Conférence est aussi intéressée dans les programmes de l'Association des infirmières canadiennes.

D. Vous aviez aussi quelque chose à nous dire concernant quelques organisations américaines d'accréditation?

B. Ce fut aussi notre privilège de visiter quelques organisations américaines dont l'Association des Collèges et Ecoles d'enseignement secondaire du Nord Central, la Conférence des Ecoles catholiques d'infirmières et la Ligue nationale du nursing.

La secrétaire de l'Association du Nord Central nous a fourni un matériel précieux sur les différentes phases de leur programme — l'un des premiers et celui sur lequel la plupart des services d'accréditation ont été modelés.

L'Association est responsable à la fois d'un service d'inspection et de consultation. Les comités nationaux sont chargés de l'orientation et les comités de districts assistent les institutions, au besoin. Des consultantes se rendent aussi dans les écoles sur demande. Ces services de consultation sont accordés également aux écoles non accréditées.

Les visiteurs sont choisis parmi des représentants des différents in-

térêts professionnels et sont recrutés presque en totalité parmi le personnel en service actif dans les écoles. Le système ne prévoit pas d'accréditation temporaire, les écoles non accréditées sont placées sur une liste spéciale en vue d'une nouvelle visite. Une fois l'accréditation accordée, une réévaluation n'est obligatoire qu'au cas où elle est jugée nécessaire; un questionnaire tient l'Association au courant du niveau de l'institution.

Avant la visite, on demande à l'école d'entreprendre un examen personnel de l'institution qui doit être une étude compréhensive et intensive du programme accompli par le personnel enseignant. Les visiteurs n'évaluent pas sur une base de standards fixes, ils observent surtout la vitalité intellectuelle. Les critères employés ont été élaborés par un comité d'experts et adoptés par l'Association; ils sont revisés périodiquement.

Le représentant que nous avons rencontré a loué hautement la valeur d'une évaluation personnelle poursuivie par l'institution et d'un système qui fournit aux écoles l'aide nécessaire à leur avancement.

Un autre programme américain bien connu est celui de la Ligue nationale du nursing. Vouloir expliquer en quelques mots leur programme d'accréditation est une tâche impossible; un programme d'accréditation et d'aide aux écoles a été élaboré sur une échelle nationale. En ces dernières années, ils ont développé un questionnaire, des critères et une technique. Ils ont aussi publié une variété de littérature sur le sujet.

Le service officiel d'accréditation fonctionne sous la direction de la division de l'éducation de la Ligue nationale du nursing. Sur demande, des examinatrices officielles visitent les écoles; un rapport est présenté au Comité central et une décision prise pour ou contre l'accréditation de l'école, selon le rapport donné par les visiteuses.

Un vaste programme d'orientation et de conseil est mis à la disposition des écoles d'infirmières, soit par l'offre de visites d'une consultante, soit par le moyen de publications diverses.

Une visite d'accréditation coûte à chaque école entre $500 et $800, environ. Une affiliation institutionnelle peut être maintenue moyennant la somme d'environ $200 annuellement fournie par l'école-membre qui désire se procurer les bienfaits du programme de consultation.

A. Qui aurait pensé que ma première question aboutirait à un véritable forum sur l'accréditation! Revenons au Canada maintenant et dites-nous ce que vous savez des plans de l'Association des infirmières canadiennes concernant l'accréditation.

B. L'Association des infirmières canadiennes est convaincue que c'est pour elle une responsabilité professionnelle d'évaluer les programmes d'éducation des écoles d'infirmières et le comité exécutif a décidé de commencer par une "étude-pilote" d'évaluation.

D. Je suppose que cette première étude se propose d'obtenir des renseignements qui permettraient de connaître le niveau de nos écoles.

C. Je croirais plutôt qu'il s'agit d'un premier stade du programme, d'une expérience sur laquelle serait basé ensuite un plan d'accréditation.

B. Les objectifs de cette étude expérimentale ont été définis par un comité spécial et formulés ainsi:

1. Voir si les écoles sont prêtes à l'accréditation et s'il est opportun d'entreprendre un tel programme à l'heure actuelle.
2. Déterminer les principes à la base de l'accréditation.
3. Etudier les méthodes et les techniques de l'accréditation.
4. Déterminer le personnel et les autres ressources nécessaires à un plan national.
5. Estimer le coût approximatif d'un tel programme.
6. Renseigner le public canadien sur les besoins du nursing.

A. Ces buts sont vraiment précis. Me diriez-vous de quelle façon le plan sera élaboré?

B. A cause de la vaste expérience de plus de vingt ans, de la Ligue nationale du nursing des Etats-Unis, le comité exécutif de l'Association des infirmières canadiennes a décidé d'inviter une représentante de

l'organisation américaine à poursuivre "l'étude-pilote" avec l'assistance de l'Association.

Il semble cependant que ce plan original sera modifié, dans ce sens que des infirmières canadiennes se rendront, sur l'aimable invitation de la Ligue nationale du nursing, au bureau central à New York, pour une période d'observation et d'étude.

D. Les infirmières américaines sont toujours si bienveillantes!

C. Alors, est-ce que ces observatrices canadiennes seront chargées de la première étude, à leur retour?

B. Nous ne savons pas encore d'une façon définitive quelle méthode sera employée; un comité a été nommé pour suivre les développements en ce domaine et présenter les recommandations jugées opportunes au conseil exécutif de l'Association des infirmières canadiennes.

Il semble toutefois logique de conclure que ces infirmières participeront activement à cette étude d'évaluation. De plus, chaque Association provinciale sera priée de recommander des infirmières qualifiées qui accepteraient d'agir à titre de visiteuses régionales. Parmi les noms fournis, un nombre déterminé de visiteuses sera choisi pour participer à "l'étude-pilote" dans une région donnée.

C. J'ai hâte de savoir comment va se faire la sélection des écoles? Est-ce que toutes seront également éligibles?

B. La méthode suggérée pour le choix des écoles est la suivante:

On demandera à chaque association provinciale de renseigner toutes les écoles de la province sur la nature du projet et de les inviter à faire connaître leur intention d'y participer, si elles sont choisies.

De la liste fournie par les associations provinciales, on choisira vingt écoles dont une au moins par province. La sélection devra prendre en considération divers facteurs, tels: l'importance de l'école, le genre de contrôle, la situation géographique, etc., afin que l'étude représente un bon échantillon des programmes préparant au diplôme d'infirmières, au Canada.

A. C'est extrêmement intéressant! Il nous faut partir maintenant, c'est avec regret, mais à notre prochaine rencontre, nous aurons à résoudre quelques-uns des problèmes que la discussion d'aujourd'hui a fait surgir dans mon esprit. Puis-je en énumérer quelques-uns?

Combien de personnes seront requises pour mettre le plan préposé à exécution?

Aurons-nous un programme canadien d'accréditation, ou participerons-nous aux services américains comme font d'autres organisations?

Quels critères emploiera-t-on pour juger les institutions visitées?

Est-ce que le personnel enseignant des écoles d'infirmières partagera la responsabilité de déterminer les critères d'accréditation?

Et finalement, qu'est-ce que tout ceci coûtera à l'association et où celle-ci trouvera-t-elle l'argent nécessaire?

D. Toutes ces questions sont très pratiques, spécialement la dernière! Donc, à bientôt.

Pertussis is still the most deadly of communicable diseases for children and kills more babies before their first birthday than all the other common infectious diseases taken together, the World Health Organization reports in a new statistical survey.

The report, which includes data gathered in many countries since the beginning of the century, says that pertussis mortality declined considerably during the first half of the century but failed to keep pace with a much greater decline in deaths from other diseases. Pertussis is also the only childhood disease that kills more girls than boys, the report adds.

In the United States, annual mortality per 100,000 inhabitants during the last five years was 0.2 among whites and 1.6 among non-whites.

The report indicates that the disease affects a greater proportion of children in southern countries (Egypt, Portugal, Italy) than in northern ones.

— *Scope Weekly*

* * *

The least expensive accident insurance is carefulness.

* * *

A hospital without a disaster program is like an army without ammunition.

Forty Years of Growing

RAE CHITTICK, M.A., M.P.H., LL.D.

I THINK IT APPROPRIATE, in speaking at the 40th anniversary of the New Brunswick Association, to cast my mind back to what has happened in the last 40 years and to forecast, as best I can, what may develop in the future. We build on our past and it would be folly to anticipate future events without having a clear conception of our history. I make no extravagant claims to a thorough knowledge of the past but I have one qualification in my favor. I have lived through the past forty years and perhaps I have a survivor's right to speak. And, as an added qualification, I may say, that most of those 40 years have been spent in nursing. It is in that direction my remarks are now directed.

One cannot speak about nursing without talking about many other aspects of our cultural development. Nursing, like any other profession, was born, developed and shaped by society's needs. Nurses did not make the nursing profession: society made it. No matter how much nurses are blamed or praised for the amount or quality of nursing in a community, they alone are not responsible. In the long run, society receives the kind of nursing it wants, just as it receives the kind of roads or government or postal service it demands.

I should like to sketch first for you some of the tremendous changes that have taken place in Canada during the past 40 years, for nursing is closely tied to the economic and social developments in this country.

In the past 40 years we have more than doubled our population. What is more, the character of that population has changed, particularly in the distribution of age groups. The very young and the elderly have increased much faster than the population as a whole. The population under 10 was, in 1953, well over half again as large as in 1941 and the group 60 and over nearly 2/5 larger. This means that at both ends of the age scale we have greatly increased the number of people who are most likely to need medical care.

We have changed from a farming people to an industrial one. Today, less than 20 per cent of the gainfully employed are in agriculture. We are rapidly becoming urbanized — about half of our population now lives in cities of 40,000 or more. We have a network of railways and highways in every province and most of the highways leading to market centres are all-weather roads. We have an efficient communication system with the long distance telephone reaching to remote farms. We have built hundreds of schools and it is the rare child who does not receive some high school education. The character, too, of education has changed. There is much less of the rigid authoritarian discipline, the rote memorization of facts set down by the teacher or the textbook. Children are encouraged to think, to discuss, to evaluate, and to find out things for themselves.

Family life has changed. Families are not likely to live from generation to generation in the same neighbor-

RAE CHITTICK

Dr. Chittick is director of the McGill School for Graduate Nurses, Montreal. She delivered this address at the banquet during 40th anniversary celebrations of the N.B.A.R.N.

hood. Industrialization has forced them to be mobile and to move where work is available. There are more family units in proportion to our population and these units are smaller. Families are often isolated from their relatives and frequently have no deep roots in any community. The emotional security and, to some extent, the financial security produced by many close relations are disappearing. The primary family unit today consists of the mother, father and two or three children. Households seldom contain grandparents, and uncles, aunts and cousins are off in establishments of their own. Furthermore, most well adults who have no home responsibilities are gainfully employed. It is the rare household that has a free adult around ready to take on an extra job.

These changes have not occurred at the same rate in all parts of Canada. They have taken place more quickly where the largest population and the greatest industry are centred, that is, in a very small part of Canada geographically — a corner of Ontario and Quebec where 60 per cent of our population is settled. The inconsistencies in our rate of development have been one of our puzzling problems, for the strength of our nation is dependent upon the development of the country as a whole, and we are convinced that all citizens should have equal privileges. One of our methods of solving this puzzle is to redistribute wealth in the form of federal grants.

Now let us look at how these changes have affected the demand for medical care. The doubling of our population means that there are more sick people to be cared for. The very young and the old are the groups in our society that need the most attention and they have increased rapidly. The growth of cities, improved communication and transportation, changes in family life and the nature of modern medical practice have resulted in an enormous growth of hospitals. This fact alone has profound implications. Human beings throughout most of their history have confronted and dealt with disease in a family — in the midst of close-knit relationships of kith and kin. Hospitalization means the sick person is isolated from his family and removed from his familiar surroundings. Frequently, he has had no close association with the doctor who is attending him in the hospital, for quite likely his family physician has turned him over to a specialist. If the patient is the breadwinner he is worried about expenses. If it is the mother in the family, she will be concerned about her children. In either case, there are no close relatives about to share the responsibility. Under pressure of labor unions, the financial burdens have been somewhat eased by many different kinds of prepaid hospital insurance plans, but they, in turn, have increased the hospital population, for no benefits are paid for the patient sick at home.

This increased demand for medical care, and particularly for hospital care, has produced great changes in nursing. Modern nursing was born towards the end of the last century with the work of Florence Nightingale. At that time the hospital population was comparatively small and the employment opportunities for women extremely limited. Under the inspired leadership of Miss Nightingale sufficient women of intelligence, integrity and purpose were attracted into the profession to lay a firm foundation for quality in nursing care. It was fortunate that they were women of such heroic proportions or the kind of nursing care in which they believed would have been wiped out by the "march of progress." The changes I have mentioned resulted in the building of hundreds of hospitals — little hospitals, middle-sized hospitals and big hospitals. All needed nurses to care for their patients. There seemed only one solution and that was to open a school of nursing. Schools were opened as fast as hospitals were built. The one requisite for a school was patients to be nursed. Sometimes even this one requisite was almost missing, for hospitals with as few as 25 beds conducted schools of nursing in various parts of Canada. Furthermore, there seemed to be no dearth of candidates for these schools for society, although now approving of women working outside the home, had not yet opened its doors to any variety of employment for women. Teaching and nursing were the sole approved occupations.

I need not dwell on the deficiencies

of these nursing schools, for most of you are very familiar with them. Admission standards were low — in 1916, many hospitals accepted students with only a grade eight education. Many schools had no library or laboratories, few, if any, qualified teachers, and little by way of a planned curriculum. The conditions under which the student worked and lived were rugged to say the least — 12-hour duty, 6½-day week, long periods of night duty, no sick leave, authoritarian discipline and severe restrictions on the nurse's personal life. Hospitals depended upon students to carry the service load — education was a secondary matter. Even as late as 1930, many large and well-known Canadian hospitals were staffed at night entirely by students, with one lone graduate on duty in the person of the night superintendent.

To prepare young girls of 18 or 20 as quickly as possible for this enormous load of responsibility required a special kind of education. It was a form of indoctrination, much as young men receive when drafted into the army in wartime. They were told precisely what to do; initiative, originality, evaluating and questioning were discouraged. Technical skills were more important than the patient's feelings — or the nurse's feelings, for that matter. Empathy for a patient was a sign of weakness on the part of the nurse and loitering at the bedside to talk to a patient, when there was nothing to be done for him, was frowned upon. It was better to go and clean the utility room or tidy the medicine cupboard. Hospitals were organized in a rigid hierarchy, with the poor little probationer at the bottom of the heap, and with little freedom of communication from one group to another.

A well-known Dean of Medicine, who graduated from McGill in 1909, had this to say about the superintendent of nurses in a large general hospital at that time.

> It was a sight to see her sailing through the wards on her daily rounds, followed by her white-clad entourage of three or four staff nurses, looking for something amiss, whether a poorly-made proby's bed or a collection of dust!

Now, this is not good education by any standard. It was perhaps, the best that society could provide at one period of our development and at the same time meet its nursing needs. I wish to assure you that much good nursing was done despite the quality of education and the working conditions. Some factors favored good nursing, such as the longer stay of patients in hospitals, and the simpler environment of the hospitals, which allowed the nurse to give total care to a patient and provided for face-to-face relationships with the doctor.

Hospitals of today have become enormously complex with many groups and categories of workers contributing to the care of patients. Doctors, technicians, internes, dietitians, nursing aides, ward aids, ward clerks, social workers and many others form part of the big team concerned with the welfare of the patient. As a result of this complex organization and, also, because the patient stays a shorter time in the hospital, it is difficult for a warm, understanding relationship to be built up between the patient and the nurse. Yet, this therapeutic relationship is the basis of all good nursing.

We recognize these difficulties and we have made many changes. Schools have improved their teaching programs; there is much less of the authoritarian approach, and fewer restrictions on the personal life of the nurse. Hospitals themselves are more homelike and comfortable. The traditional white has given way to pretty colors; small units have taken the place of the big wards; easy chairs and attractive sitting rooms have been introduced; rules and regulations are less rigid; nurses are encouraged to talk to and listen to patients instead of hiding in cupboards when they can't find anything to do with their hands.

Yet nursing hasn't kept pace with the needs of society nor with the enormous strides that medicine has taken towards understanding the nature of illness. I should like to mention one or two facets of these strides, for they have profound implications for nursing.

Epidemiological techniques, so successful in controlling communicable diseases, are now applied to all ill-

nesses. In essence, this is the recognition that every disease arises from many causes. It is not sufficient to find a specific organism or agent, but one must consider the patient's personality, the value system he recognizes, and the environment in which he lives. This point of view has been strengthened by the contribution of the sociologists and the anthropologists. They have awakened us to the fact that our culture plays a large part in our illnesses. Because it is easier to see these influences in other societies than in our own, I should like to tell you a story to illustrate the close relationship between patterns of culture and sickness.

Dr. John Cassell,[1] working in South Africa with a Zulu group, relates that he was called in one day to see an old Zulu man who had a cavity in the apex of one lung. It was apparently a very severe case of tuberculosis and the prognosis was extremely poor. The doctor advised the family to come to the clinic for drugs. They did not do so. Instead, they called in a woman witch doctor whose diagnosis was that the old man was the victim of witchcraft perpetrated by the man's only son and the son's new bride. Incensed, the old man drove the couple from his home and took steps to disinherit his son. A month later Dr. Cassel was surprised to learn that the old man, instead of dying, was up and about.

The physician decided to go more deeply into the story. He found that the son was a ne'er-do-well who squandered his father's money in town. He came home at intervals and demanded the goats and cattle be killed and a feast be prepared in his honor which, according to Zulu custom, were legitimate demands of an heir. Without asking the father's consent the son married an undesirable town girl and persuaded the unhappy father to part with eleven head of cattle for the "bride-price" and to take the girl into his home. Eventually she committed the rudest of social breaches; while quarrelling with her father-in-law she spat in the old man's eye!

At that point, the old man became ill, and Dr. Cassell was called in, to be followed by the astute witch doctor who branded the son and daughter-in-law as malevolent agents. In Zululand the symptoms of bewitchment include loss of weight and spitting up blood — virtually the same as those of tuberculosis. Dr. Cassel remarked, in retrospect: "When I was called in to diagnose the case, my total diagnosis consisted of a hole in the lung, and I missed all the psychological and cultural factors. The witch doctor, on the other hand, had diagnosed the whole set-up and had missed only the hole in the lung. Of the two, I should imagine that her diagnosis was more complete than mine."

This comprehensive approach to the nature of illness has been stimulated further by our efforts to understand the cause of mental illness. One cannot approach this phase of our development without mentioning the work of Sigmund Freud. (This year marks the centennial of his birth and his outstanding contribution is being widely recognized). His work has penetrated into nearly every aspect of life — literature, the theatre, the plastic arts, law and, of course, very deeply into medical thought and practice. Freud introduced into medicine the function of meaningfulness in biological phenomena — not only did he demonstrate that nothing in the operations of the individual is ultimately irrational — neither dreams, nor forgetfulness, nor slips of the tongue, nor errors, nor neurotic or psychotic behavior — but that the whole of the individual's living experience is animated with purpose and intention. More often than we suspect, the decisive clue to the remedy of a disorder can more easily be gained from an assessment of the functions of the illness, than from the study of its specific causes. In other words, what meaning has this illness for the patient?

These contributions have added, so to speak, a fifth dimension to medicine. Moreover, they have made us realize that we have been carried away by the tremendous developments in science and have been neglecting healing as an art.

I have dealt with only a few of the immense changes to which the nursing profession must adapt itself and have indicated the social movements and the developments in medical thought and practice that are influencing nursing so profoundly. However, it is enough to give you some idea of

the great distance nursing has travelled since this Association was founded 40 years ago. From this background a number of conclusions are quite obvious. One is that we have created a situation in which it is impossible for a nurse to give total care to patients. Even if we could overcome the difficulty of numbers, the modern organization of a hospital and the trends in the practice of medicine are involving more and more people with special skills. Nurses must find their place and make their best contribution in this much bigger team. The effectiveness of this contribution is based on a deeper understanding of our culture and of the nature of man himself.

Nursing is an art practised in a scientific and humanitarian setting. Its objective is to meet the needs of each patient and work for the maximum effect of the treatment program prescribed by the doctor. I don't know how you would define an art in your own minds, but you would admit that it is made up of skill in performance acquired by experience, study and observation; that it shows human ingenuity and discernment. Montaigne says of an art that it is not cast in a mould but is formed and perfected by degrees, by often handling and polishing as bears, in leisurely fashion lick their cubs into form. This is a subtle comparison for it implies love and understanding, dexterity and discipline, gentleness and patience, and the element of time.

As I see this polishing, it involves many things — a greater knowledge on the part of the nurse of the biological and social sciences so that she may have insight into the manifold urges and drives of life itself and an understanding of the kind of society in which she lives. It implies greater skills in communication between nurse and patient, nurse and nurse, nurse and doctor; ability to involve the patient in his own therapy (we don't do things to or for the patient, but *with* the patient); ability to teach and to supervise, to plan and to organize; the capacity to be increasingly self-analytical in order to search for better ways of doing things; the ability to discriminate between what is important to be done and what may be postponed when demands outrun time.

Albert Schweitzer recommends that when talking of an art one should speak in parables, and for this parable I am about to relate I am indebted to Lucile Petry Leone,[2] Chief Nursing Officer, United States Public Health Service. It is the story of her young friend Joe and the nurse who cared for him at a critical time in his life.

Joe was born with a defect in his trachea. It could not be corrected by surgery until he was 18 months old. At that time came hospitalization and then the day of operation. His evening nurse found him just out of the anesthetic, sobbing, tossing, frightened at the strange new way of breathing. She searched the ward to find a rocking chair for his room. Before it she placed a table holding the electric suction pump and the tray of equipment for clearing the tracheotomy tube. She sat all night long with Joe in her arms. Frequently, she leaned forward in the chair to turn the switch and apply suction to Joe's tube. Secure in her arms, Joe slept fitfully. Freed from his preoccupation with fear, he soon began to associate the whir of the motor with relief from choking. The nurse noted that even before she could detect that breathing was difficult, he would turn his eyes and make small gestures towards the table. She began holding his fingers over the switch when she turned the motor on. By morning Joe had learned. When the tube needed clearing, he would stir and reach. She rocked forward, he turned on the switch, and she applied suction to the tube.

When Joe was three years old Mrs. Leone visited the family. As she sat chatting with the mother in the kitchen, the screen door banged and she heard running footsteps into the bedroom and then a whirring sound. At Mrs. Leone's question the mother said, "Yes, Joe still has his tracheotomy tube but soon he can get along without it. Ever since he left the hospital he has known how to suction it himself. He seldom needs help. He plays actively with other children and runs into the house when he needs to clear the tube. He never thinks of himself as handicapped." Mrs. Leone paused to reflect on what might have happened if on that night more than a year before his nurse had used a restraining sheet instead of a rocking chair.

The nurse did not meet Joe's needs intuitively but from a deep knowledge of how personalities develop. She understood Joe's emotional reactions to threats to breathing and to restraint. She knew that her own anxiety or her sureness would be communicated to him. Her understanding encompassed a long time-span, and the relationships between what happened today to what could happen next year were clear.

This is a story that reveals the art of nursing with its wide range of values. It is an art that deals with the future as well as the present, with prevention as well as healing, with rehabilitation and adjustment to family and community life. Moreover, it is seldom a solo performance. Behind the competent performance of this nurse was the work of many — those who taught her to understand the needs of children; those who helped her gain scientific knowledge and definite skills; those who gave her security and self-confidence; those who encouraged her to develop imagination and initiative; and lastly, those administrators who were far-seeing enough to countenance and to provide a rocking chair and to encourage its use when its value was essential.

I am not prepared to say what is the best way to develop this kind of nursing, but I think you realize that we have outgrown the old pattern. Nursing today requires a very high quality of teaching and we are desperately short of teachers. It requires a broad curriculum that is stimulating and challenging, with time for students to investigate, to read and reflect, as well as to gain experience at the bedside. It requires the enthusiastic cooperation of the nursing profession and of society itself. People must want this kind of nursing and play a very large part in bringing it about.

You in New Brunswick have been studying your particular problems and I wish to congratulate you on this undertaking. I understand that you are making some very sound plans to provide good nursing for the people of this province. You will need a great deal of help from many groups of people and a willingness on the part of the nursing profession and of society to accept change. I wish you every success in your endeavors.

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Edema

Research has revealed that the adrenal glands of dogs with edema secrete excess aldosterone, the body's major salt and water regulating hormone. Concerned with the causes of edema which afflicts millions of persons with heart, kidney, and liver diseases, scientists have implicated the adrenal hormone, aldosterone, as an important factor. Aldosterone is known to function in the normal regulation of fluids and salts in the body, and excess quantities of this hormone have been found in patients with edema. However, prior to the new findings, it was not known whether this excess of aldosterone was due to its overproduction by the adrenals or to its accumulation because of some defect in the normal mechanism for destroying it in the body. The new findings strongly suggest that overproduction by the adrenals is largely responsible for the excess aldosterone of congestive heart failure, a common late phase of many heart disorders.

The researchers collected blood for aldosterone measurement directly from the veins draining the adrenal glands of three normal dogs and five dogs with circulatory disorders which had resulted in edema. They found that aldosterone appeared in the adrenal blood from the normal dogs at an average rate of 2.7 micrograms per hour, while the average aldosterone secretion rate in the dogs with heart disease was 14.5 micrograms per hour.

— U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

* * *

If you have a healthy body you are living in a palace, no matter what your station in life.

Nursing Profiles

Jeanette V. White who, as managing editor of the *American Journal of Nursing*, attended the CNA convention at Banff in 1954 and became acquainted with a wide circle of Canadian nurses, has succeeded to the post of editor of the American nurses' publication.

A graduate of West Suburban Hospital, Oak Park, Ill. and holding her B.S. degree from Teachers College, Columbia University, Miss White's interest in writing predates her first association with the A.J.N. in 1949 by many years. "My interest in writing dates back to the age of eight when I submitted a story in a contest being conducted by a local newspaper. It did not win a prize but the writing bug had bitten me and from then on I was writing, or helping someone else to write whatever else I was doing."

"Whatever else" covered a diversity of interests for before she decided to enter nursing Miss White worked for a firm of consulting engineers. While so employed she studied mathematics and cost accounting with the intention of working for her degree in mechanical engineering. Instead, following the completion of her undergraduate course in nursing, Miss White engaged in general duty nursing then became a teaching supervisor in psychiatric nursing. All of the while, her interest in writing was being fanned by courses in journalism and writing at universities in Chicago and later in New York. She is a member of the American Medical Writers Association.

(Altman-Pach Studio, New York)

JEANETTE V. WHITE

Grace A. Motta assumed her new duties as registrar of the Saskatchewan Registered Nurses' Association in September, 1956. A graduate of Winnipeg General Hospital, Miss Motta's experience as director of nursing of the Moose Jaw Union Hospital since 1943 has given her a wealth of sympathetic understanding of the needs and problems of nurses seeking recognition as registered nurses. She is very familiar with the professional association side of registration, too, by reason of her long service on the Council of the Saskatchewan Registered Nurses' Association, including a two-year term as president. A member of the Business and Professional Women's Club, Miss Motta uses some of her spare time in needlework. She is also interested in collecting unique pieces of china.

GRACE MOTTA

Ella Donnelly is now the director of nursing services for the Saskatchewan Division of the Canadian Red Cross Society. A graduate of St. Paul's Hospital, Saskatoon, Mrs. Donnelly served as superintendent of nurses at hospitals in several small Saskatchewan communities prior to her marriage in 1933. She returned to active nursing in 1948 when she joined the staff of the Ottawa

Civic Hospital as head nurse on a surgical ward. In 1951, Mrs. Donnelly became the parental care supervisor and matron of the Saskatchewan Boys' School in Regina. She resigned from that post in 1953 to become assistant registrar with the Saskatchewan Registered Nurses' Association, which position she vacated in May, 1956.

ELLA DONNELLY

Evelyn M. Watts became the director of nursing at Humber Memorial Hospital, Weston, Ont., early in November 1956 after serving for eight years as assistant director of nursing at Deer Lodge (D.V.A.) Hospital in Winnipeg. A graduate of Hamilton General Hospital, and in public health nursing from the University of Toronto School of Nursing, Miss Watts worked with the Ontario Red Cross Outpost Service and the Hamilton Health Department before enlisting in the R.C.A.M.C. in 1942. Following three years service in Canada and overseas, she completed the course in nursing administration at the McGill School for Graduate Nurses. Miss Watts served one term as president of the Manitoba Association of Registered Nurses.

(Jacoby, Montreal)

EVELYN M. WATTS

Norena Mackenzie has taken over the responsibilities of director of nursing and principal of the school of nursing at the Jewish General Hospital, Montreal. A graduate of The Montreal General Hospital and in teaching and supervision from McGill School for Graduate Nurses, Miss Mackenzie spent many years as an instructor, later as director of nursing education, at M.G.H. She also taught at the Hospital for Sick Children, Toronto. For some years she was director of nursing at Jeffery Hale's Hospital, Quebec.

When the United Nations Relief and Rehabilitation Administration took over the vast responsibilty of providing for homeless peoples, Miss Mackenzie was one of the Canadian nurses whose skills were welcomed. She served in Italy and later organized an educational program for nursing assistants in Germany. Immediately prior to her present work she was chief instructor at the Jewish General Hospital.

NORENA MACKENZIE

Elizabeth Rosemary Summers is the director of nurses at the St. John's General

Hospital, Newfoundland. A native daughter of that province, Miss Summers taught domestic science in St. John's for four years before she entered her training at Halifax Infirmary. Soon after graduation she joined the nursing service of the Royal Canadian Navy. She enrolled in the McGill School for Graduate Nurses following her war service, securing her Bachelor of Nursing degree in public health nursing. In 1948 she joined the nursing service of the Newfoundland Department of Health as director of staff education. More recently she was

(Van Dyck, Montreal)

ELIZABETH SUMMERS

associate director of the nursing service. Before taking over her new post Miss Summers spent several months at university in the United States studying administration of schools of nursing.

In 1951 Miss Summers was elected president of the Newfoundland Graduate Nurses' Association. She took a very prominent part in the preparatory work that led to the Act, passed by the provincial legislature, that brought the Association of Registered Nurses of Newfoundland into being. As president, Miss Summers represented the association when it officially joined the Canadian Nurses' Association in 1954.

ORMA J. SMITH

Orma Jacklin Smith is now the director of nursing at the Saskatoon City Hospital. Born in Saskatchewan, Miss Smith graduated in arts from the university there before beginning her training at the Vancouver General Hospital. Postgraduate study included a course at Toronto Psychiatric Hospital and another in administration in schools of nursing at the McGill School for Graduate Nurses.

During World War II Miss Smith served for three years in the South African Nursing Service. Prior to the war she had been on staff at the hospital in Burns Lake, B.C., matron of the Enderby, B.C., hospital and head nurse in the private pavilion at Vancouver General. Following her course at McGill after her war service Miss Smith has been successively director of nursing at Galt Hospital, Lethbridge, Alta., and at the General Hospital, Saint John, N.B. In 1950, she pioneered a new service as adviser to schools of nursing throughout Alberta then returned to British Columbia as chief instructor at the Provincial Mental Hospital, Essondale.

In Memoriam

Margaret (Campbell) Baker, a graduate of Grace Hospital, Winnipeg, died at Kenora, Ont., in September, 1956 at the age of 24.

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Agnes (Sheather) Berry, a graduate of Riverdale Hospital, Toronto, died at Chatham, Ont., on September 23, 1956 in her 59th year. Mrs. Berry was the first chairman of Kent County chapter in District 1 of the R.N.A.O. and contributed much to its early organization.

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Lillian (Hoffman) Brown, who gradu-

ated from St. Luke's Hospital, Ottawa, in 1904, died on October 28, 1956 following a brief illness.

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Anne Isobel Browne, R.R.C., the first matron of St. Peter's Infirmary, Hamilton, died there on September 11, 1956 at the age of 89. She was in charge of a British military hospital during World War I, coming to Canada in 1925. She retired from active nursing in 1938.

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Blodwen (Hughes) Farquharson, who graduated in 1911 from Edmonton City, now Royal Alexandra Hospital, died at Victoria on July 28, 1956 following a very brief illness. Mrs. Farquharson was the Child Welfare nurse in Moose Jaw, Sask., from 1930 until her retirement in 1945. She had resided in Victoria for the past four years.

* * *

Therese (Williamson) Gartshore, who graduated from Royal Victoria Hospital in 1903, died on June 3, 1956.

* * *

Viva Iris Jean Hamill, a graduate of Soldiers' Memorial Hospital, Orillia, Ont., died suddenly following a heart attack on September 21, 1956 at Bracebridge, Ont. She was in her 53rd year.

* * *

Pearl Heninger died at Magrath, Alta., on September 29, 1956 at the age of 74. She had operated her own maternity hospital for many years.

* * *

Nettie M. Hunter, who graduated from All Saints Hospital, Springhill, N.S. in 1925, died there on September 21, 1956 at the age of 66. Until a few months prior to her death Miss Hunter had been actively engaged in nursing.

* * *

Ives King, who served the employees of T. Eaton Co., Winnipeg, as store nurse for 29 years, beginning in 1910, died at Vancouver on November 13, 1956.

* * *

Violet L. Kirke, a charter member of the Registered Nurses' Association of Nova Scotia, died at Newburyport, Mass., on October 1, 1956 at the age of 82. Graduated from the Massachusetts General Hospital, Boston, in 1905, Miss Kirke was superintendent of nurses of Victoria General Hospital, Halifax, for a time. She had retired from active nursing in 1938.

* * *

Ada May Lamb, who graduated from Toronto General Hospital in 1919, died at Toronto on September 15, 1956 at the age of 75. Miss Lamb, who retired from active nursing ten years ago, had been in poor health for some time.

ALETHA MCLELLAN

* * *

Mary A. (Minnie) Lee, a graduate of Sarnia General Hospital, died at Chatham, Ont., on August 15, 1956 following a lengthy illness. Miss Lee served in the operating theatre for a number of years then became superintendent of nurses at Sarnia General Hospital in 1931. She had engaged in private nursing at Chatham in recent years.

* * *

Anne Elizabeth MacKenzie, one of the early graduates of Victoria Hospital, London, Ont., died on October 15, 1956 in her 85th year.

* * *

Aletha McLellan, who in 1911 became the second school nurse in Vancouver, died on September 27, 1956, following a brief illness. She was 75 years of age. Miss McLellan was made supervisor of school nursing when the Metropolitan Health Committee was established in Vancouver in 1936. Two years later she became director of nursing service. She retired in 1941. A charter member of the Registered Nurses' Association of British Columbia, Miss McLellan maintained an active interest in nursing affairs and welfare work to the end of her life.

* * *

Enid (Leger) Messiah, who graduated from the Royal Victoria Hospital, Montreal, in 1912 died in Barbados, B.W.I., in October, 1956.

Margaret Joan Muttart, who graduated from the School of Nursing, University of Toronto, in 1954 died at Summerside, P.E.I., in September, 1956, after an illness of several months, at the age of 25. For the past two years Miss Muttart had engaged in public health nursing in the Nova Scotia provincial health service.

* * *

Laura E. Page, who graduated from Victoria General Hospital, Halifax, in 1925 died there in May, 1956 after some years of ill-health. Miss Page had served on the staff of V.G.H. for many years.

* * *

Sister Mary Gonzaga, a graduate of St. Joseph's Hospital, Peterborough, Ont., and a member of the community of the Sisters of St. Joseph's of Peterborough Diocese for 34 years, died there on October 13, 1956 after an illness of six months. Serving as director of nursing at St. Joseph's since 1930, Sister M. Gonzaga gave strong leadership in nursing through the years. She had served on the executive of the Ontario Conference of the Catholic Hospital Association, including a term as president. She was also president of District 6, R.N. A.O. and a member of the local advisory board of the Community Nursing Registry.

Sister Mary Modeste, of the community of St. Ann, a graduate of St. Joseph's Hospital, Victoria, died there in August 1956. Sister M. Modeste served on the staff in Victoria for many years. In 1923 she went to St. Ann's Hospital, Juneau, Alaska where she worked as chief operating nurse and pharmacist until her retirement in 1952.

* * *

Margaret W. Thomson, who graduated from Toronto General Hospital in 1908, died at Hamilton on September 20, 1956.

* * *

Blanche (Bessett) White, who graduated from Royal Victoria Hospital, Montreal in 1926, died at Saint John, N.B., on September 16, 1956. Mrs. White was a past president of the Saint John chapter of the R.V.H. Alumnae.

* * *

Maude M. Wright, R.R.C., who graduated from Royal Victoria Hospital, Montreal, in 1912 died in Montreal on October 15, 1956, from injuries received in an accident. Miss Wright served overseas with the C.A.M.C. during World War I. She was twice mentioned in despatches and was awarded the Royal Red Cross. Miss Wright's professional life was devoted to private nursing.

In the Good Old Days

(*The Canadian Nurse* — JANUARY, 1917)

The main factors in the treatment of all contagious diseases are: Sunshine, fresh air, soap and water, and careful nursing. Antistreptococcic serum has been used in scarlet fever and erysipelas — has been given a good trial, and found wanting. In the case of diphtheria, it is different. The results of the serum therapy have been wonderful!

The diet in scarlet fever is very rigid. The best results are shown where an absolutely "milk only" diet for at least three weeks is adhered to, with copious draughts of cold water.

* * *

In Canada, the need for doctors and nurses has not been felt in any of the cities, larger towns, or thickly populated districts. In sparsely settled districts there is a need. There, no one but the fully trained woman, the woman with experience, with practical knowledge of everything pertaining to the domestic side of our life, the woman imbued with the importance of her task and with a sincere faith in the future of the country districts will solve the problem of providing nursing care in the isolated districts of Canada.

* * *

His Royal Highness, the Duke of Connaught opened the Ross Memorial addition to the Royal Victoria Hospital, last October, using a golden key.

* * *

The Alumnae Association of the Montreal General Hospital has decided that, owing to the extra strain and work on the doctors because of the war, they should not be asked to give lectures at the monthly meetings.

The best remedy for insomnia is not a pill. It is the conviction that you have done a good day's work.

SPOTLIGHT

Let us Find Some Answers and Tell Others

RAE CHITTICK *and* MOYRA ALLEN

"How is everything this morning?" asked the head nurse, as she stopped by the patient's bed.

"Everything is fine — in the morning. It is the afternoon and evening I can hardly bear," replied the patient.

"Why is that period so terrible?" questioned the head nurse.

"Oh, the nurse on the afternoon shift is dreadful. She isn't interested in me, just in herself and the internes. She comes in, says it is too cold and closes the window. I lie here full of tubes and can't do anything about it until the night nurse comes on duty. She is a wonderful person who really looks after her patients."

"Couldn't you call someone to open the window for you?" said the head nurse.

"Yes, I suppose I could, but I don't want to make myself a nuisance."

The first thought in the head nurse's mind as she walked down the hall was that here was another complaining patient who didn't know what she wanted. "There is no pleasing some people," she said to herself.

But the head nurse was interested in her patients and wanted them to have good care. As she went about her work the patient's dissatisfaction kept recurring in her mind. "Could it be that her complaint is justified?" she thought. "Was the nurse concerned at fault? Were other patients dissatisfied? Were there enough nurses on duty to look after the needs of all patients?" It was a problem requiring some investigation and she must study the situation to find out the facts. Here in its nascent state was a *research problem.*

Miss Chittick and Miss Allen are faculty members of the School for Graduate Nurses, McGill University, Montreal.

WHAT IS RESEARCH?

Many people are frightened by the term research. They think of it as an involved process requiring special training and considerable time and money. It is true that some kinds of research require special preparation, a knowledge of statistics and considerable time to devote to the project. There are many other forms of research that are simple undertakings that can be carried out by all nurses as part of their daily work. In essence, research means recognizing a problem, organizing a method to study it, collecting the facts in an orderly fashion, and coming to some conclusions in the light of the data revealed by the study. It is promoted by an enquiring attitude of mind that is constantly speculating on better ways of doing things. C. F. Kettering defines this state of mind as a friendly, welcoming attitude toward change:

> It is a going out to look for change, instead of waiting for it to come. It is an effort to do things better, and not to be caught asleep at the switch.*

THE NEED FOR RESEARCH IN NURSING

Progress in any profession is founded on research. It is the vital spark that stimulates change, for it arises from feelings of dissatisfaction and draws its conclusions from established facts. Nursing has been reluctant to accept research methods because it has been governed by tradition and

*C. F. Kettering, as reported in the article, "More Music Please, Composers!", *Saturday Evening Post,* Sept. 10, 1938, quoted here from the article entitled "We Can Use the Research Approach," by Francoise R. Morimoto, *A.J.N.*, Aug., 1956, p. 1006.

emotion, both of which are particularly destructive of the research attitude. It is true that the profession has sponsored some major pieces of research, such as the study conducted at the Metropolitan School of Nursing in Windsor and the Head Nurse Study done in the Ottawa Civic Hospital. The need for big studies like these is evident but there is also a place for countless small studies done by many nurses in the course of their daily work. In this day of rapid change in medical care, many nursing procedures and hospital routines have outlived their usefulness, but because nobody has questioned their continuance, or experimented to find more satisfactory practices, they continue to be the accepted methods.

Many times patients or their friends who have had occasion to take a good look at nursing have raised pertinent questions. We hear enquiries like these from time to time: "Why must nurses do so much paper work at the desk? Why do hospitals waken patients out of a sound sleep to give early morning care? Why isn't there greater freedom in visiting hours? Why do all patients need drawsheets? Why cannot mothers stay on the wards to give care to their own children? Why doesn't somebody prepare patients for the many diagnostic tests?" Is it not time that we raised more of our own questions and took steps to find the answers? The scope of such research is tremendous, for it includes countless problems of nursing service, of teaching, and of administration.

Elements in research

Behind all research is the enquiring mind that is curious to discover new knowledge or to search for better ways of doing things. This state of mind must be fostered by an environment that supports investigation and is conducive of change. Stimulated by such an atmosphere staff members will begin to raise questions, formulate problems for investigation, and seek ways of finding the answers. Once the problem is discovered, it must be defined precisely so that the scope is determined and the boundaries clearly established. The purpose of the study must be set down and an hypothesis or guiding assumption should be formulated. Methods of conducting the study must be worked out carefully and, if need be, tested by a pilot study. When the facts are collected they must be organized into a form that lends itself to an analysis so that honest conclusions can be reached. The investigation should be reported so that others may profit from the study.

An important proposal

There is a feeling that many people are now carrying out important investigations but they do not look upon them as research studies worthy of publication. Often the results do not go beyond the department or institution in which they are done. Consequently, many who could profit by these studies are unaware that such investigations have been made. Many more nurses could be encouraged to carry out research projects if they were stimulated by reading of the investigations done by others. With the approval of the Editorial Board, this *Journal* proposes to open a department devoted to research investigations. In this section will appear helpful suggestions on how to do research, reference or summaries of investigations carried out in Canada and abroad, and suggestions for new studies. It is hoped that Canadian nurses will use these pages to report their investigations into various problems. The studies may be big or small and may vary in scope from the best way to stack linen or disinfect thermometers to such major projects as assessing staff requirements or determining the kind of curriculum which best prepares a nurse to meet the needs of modern society.

We trust that this section will be widely read, that it will stimulate research projects and that the methods used and the conclusions reached in many studies will be reported in these pages for the benefit of all. Remember that research is a professional responsibility essential to the improvement of nursing.

* * *

If as hospital administrator, you are "tied to your desk," you are doing only part of the job. Remember that vision is part of supervision.

Si Vous Avez Trouvé la Réforme, Dites-la aux Autres

Les auteurs de cet article relèvent un fait banal, un malade se plaignant que sa fenêtre est fermée quand il la voudrait ouverte. Cet incident conduit l'hospitalière à analyser la situation et comme ce bon Monsieur Jourdain elle fait de la recherche sans le savoir.

Qu'entend-on par recherche?

Reconnaitre un problème en faire l'étude, réunir les faits avec ordre et en tirer une conclusion d'après les faits recueillis. En d'autres mots faire un effort pour améliorer les choses.

La recherche en nursing est-elle nécessaire?

Le progrès dans chaque profession est basé sur la recherche. Dans la recherche, les sentiments de satisfaction de la tradition doivent céder la place aux faits.

Les infirmières ont fait de grandes recherches dans le passé, enquête Weir, Civic Hospital, Ottawa, Ecole de Windsor. Mais il y a une quantité de petites choses, plaintes des malades, du personnel etc, qui mériteraient d'être étudiées. Nous pourrions alors tirer des conclusions basées sur des faits qui amélioreraient la situation.

Eléments de la recherche

Un esprit en éveil, avide de savoir afin d'améliorer: Définir un problème, déterminer exactement son étendue. But de la recherche entreprise et hypothèse entrevue. Déterminer les moyens à prendre pour faire l'étude. Tirer des conclusions honnêtes et en faire participer les autres.

Une invitation importante

Tout le monde fait de la recherche dans les petites choses. Souvent le résultat ne dépasse pas le seuil d'une salle ou d'une institution quand il pourrait être si utile à d'autres.

L'Infirmière canadienne a donc décidé de consacrer une section de la revue à la recherche et invite toutes les infirmières à y collaborer.

When Nurses Talk Together

Jean Scott *and* Fern McCready

What constructive thinking and practical suggestions would you expect if nurses met?

(a) From all areas of nursing — undergraduates, graduates doing floor duty, private nursing, nursing education, supervising, public health, directors of hospitals and inactive married nurses;

(b) from widely separated geographical areas;

(c) from various types of hospitals and health departments;

(d) of various religious faiths;

(e) brought together for 45 hours in a beautiful place set apart by a river, surrounded by hills and trees, (in one of the trees a family of baby raccoons frolicked);

(f) completely free to discuss nursing in anyway whatsoever — without a nursing leader or set program.

Believe it or not there was no confusion or waste of time. This happened at Five Oaks on April 27-29, 1956. Five Oaks is a Christian Workers Center situated on a beautiful 25-acre site on the Grand River just two miles from Paris, Ont. The year-round building accommodates 60 over-night guests and the summer centre 120.

The key statement of the Conference was, "We believe that true wor-

Miss Scott is at Sarnia General Hospital while Miss McCready is at Hamilton General Hospital.

ship of God includes the whole life of a person. For a nurse, this part of this whole, would include what she is and does during her on duty hours." The discussions were grouped under broad headings:

1. *Is the service motive declining in the nursing profession?* Those who felt it was, gave three possible reasons: (a) Physical fatigue — not necessarily from overwork on duty. (b) Indoctrination by fellow workers whose philosophy is to give as little and get as much as possible. These people have become vocal in our profession because, during the acute shortage of nurses, administrators have been forced to accept almost anyone that promised an extra pair of hands on the wards. (c) Inadequately prepared people forced to accept responsibility prematurely — this included students, floor duty nurses, supervisors, and administrators. (d) What of the question — are we to remain a profession or join the ranks of the labor unions?

2. *Conduct problems:* The students felt keenly about the faculty being suspicious of them — actually making a student feel she was guilty until proven innocent. Out of this grew the question of students living in residence and being *trained,* instead of maturing in a home, of being educated and of having a counsellor who was not responsible to the school office and whom the students could trust implicitly.

Other points covered under this broad heading were the taking of drugs, (not necessarily narcotics) petty thieving, alcoholic beverages, sex problems.

Supervisors were criticized for their lack of courtesy, particularly in correcting or reprimanding students before others.

Dr. E. V. Metcalfe from London, Ont., summarized psychoses and neuroses ably and quickly, reminding us all that to some degree, no matter how slight, we all had followed the thinking pattern of the psychotic and neurotic. Again we realized the tremendous need for research in this field.

There was more than discussion of nursing problems. Interspersed throughout were brief Bible discussion groups, who were provided with questionnaires with the central theme "water" such as the cup of water and its reward, the spring of water within you, the water of Life. Incidently it rained almost continuously.

Saturday night we went to bed with the music of a folk dance in our ears and on Sunday morning awoke with the song of birds as we prepared for a Communion service. Mrs. Wilma Shackleton of St. Thomas talked to us on the importance of daily devotions in the life of a nurse. (see January, 1956 issue of *The Canadian Nurse* for Beatrice MacLean's article.

The question had been asked — "What can a nurse say to help her patients or their family when death seems inevitable?" Rev. Beverly L. Oaten not only gave us his thinking but made us think profoundly and realistically about birth and death, until we felt quiet and sure, down deep inside.

Later a neighbor dropped in for a chat — Mr. Ralph Howlet who is opening a centre across from Five Oaks for those who are emotionally disturbed or suffering from various neuroses. It will accommodate 15 to 20 people, referred by their doctors. They will be under the care of a psychiatrist, psychologist, specially qualified nurses and a minister at the center for from six weeks to two months.

The last period on Sunday was spent in an evaluation of the weekend:

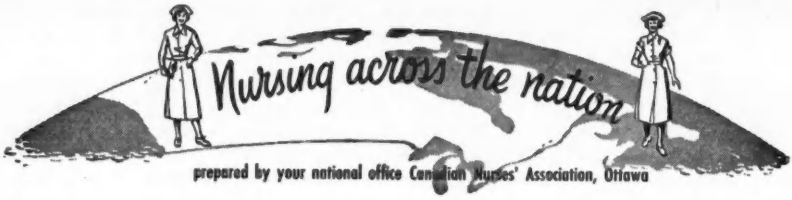
(1) What was the value of the Conference?

(2) What are the next steps for this group?

(3) Future conferences and their nature.

With one accord the nurses agreed that the weekend had been of inestimable value to all, in the evaluation of our profession, it problems, and trends. Of equal value were the atmosphere of worship which pervaded Five Oaks and the fellowship with other Christian nurses.

We covered a lot of ground in one weekend but so much remained untouched — for instance doctor-nurse, clergy-nurse relationships and the felt need for the guidance of the leaders of our Provincial Nurses' Association. As we were having the last cup of tea we realized we had only just got started so we didn't say farewell because we are coming back again.



Greetings — 1957

A very Happy New Year to you all! In these critical and anxious times we are very much aware of our fellow nurses in other parts of the world and of the citizens of the countries which do not enjoy the freedom and peace of our land. Let us hope and pray that they too may find, in 1957, hope and encouragement to carry on the humanitarian work that is nursing. For nursing is, continually and everywhere, being called upon to perform greater and more difficult tasks as society increases in its complexity. To all who care for the welfare and health of others, Godspeed for 1957.

Quality Nursing Care

"Improving the Quality of Nursing Care" was the topic chosen for a conference sponsored by the Registered Nurses' Association of Ontario. This was the first of a series of conferences planned by the R.N.A.O. Committee on Nursing Service. Over 100 nurses attended from all fields of nursing.

Panel discussions, demonstrations, role playing, films, special speakers and small group discussions provided variety in the program. There was variety also in the people taking part in the program. Included were: patients, family members, a psychiatrist, psychologist, a leader from the field of adult education, nurses in all types of positions from all fields and auxiliary nursing personnel.

The following are a few of the thoughts and ideas which were brought out in the week's discussion and express the tenor of the whole conference:

Nurses must learn to listen with real interest and concern to the problems of patients and their families; they need an awareness and sensitivity to the needs of individuals and a creative attitude in meeting these needs.

Nurses must recognize the patient as a member of a family and realize that when one member of the family is ill, the whole family is disturbed and under stress.

Motivation is important in the work setting; the worker needs recognition — to be aware that he is regarded as desirable and important to the whole organization — that his needs are recognized — his needs for status and prestige which are just as important as his physical needs.

Words and actions convey not only ideas, but also feelings and people respond not only to the ideas but also to the feelings, "not what you say but the way you say it."

We must seek self-knowledge. This is not the same as self-preoccupation but an understanding of ourselves. Growth is self-realization.

Groups are part and parcel of life and are becoming more complicated and more interdependent. The family is a group. It is in the family that our basic needs are satisfied and it is through the family that the child becomes socialized. Effective communication between members of the group is most important.

Authoritarian leadership provokes hostility and agressiveness. Democratic leadership has proven to be more effective, more satisfying and can be more efficient. People resent arbitrary decisions and changes but when they are consulted and understand the reasons, purposes can be accomplished.

Nurses need outside interests or may become ingrown and lose perspective. You enrich your profession by being a person with broad interests.

Set your sights very high. Most people are capable of much more than they have ever done.

"The greatest wisdom is still kindness." Be kind to those around you, that they may be kind to others.

"Service is the rent we pay for our room on earth."

The Russell Report

An account of the 1956 Annual Meeting of the New Brunswick Association of Registered Nurses appears elsewhere in this issue but in reporting for Nursing Across the Nation, it is not possible to omit mention of the "Report of a Study of Nursing Education in New Brunswick" by Edith Kathleen Russell, R.N. submitted to the meeting. Upon the completion of a year's intensive study of nursing education in that Maritime province, Miss Russell has produced an analysis of nursing education which has many implications for other Canadian provinces.

Although the project was directed specifically towards the "study of ways and means of reorganizing nursing education in New Brunswick in order to provide more adequate nursing service,"[1] the background material provides a searching examination of nursing and nursing education far beyond provincial boundaries. Miss Russell's description of the content of present-day nursing underlines the inadequacies of our system of preparing the majority of nurse practitioners. On page 25 is found a statement which seems to have provided the basic theme for both the study and the recommendations.

> Both groups — the nurses and their associates — need now to provide:
>
> 1. long and careful analysis of available evidence; and
> 2. willingness to break with the past where this is indicated.

Nursing need not stand alone in its present quandary. Our many colleagues in the allied professions of health, welfare, and education can contribute much to both the recognition of our problems and their solution. There is a growing understanding of the importance of all disciplines working closely together in the promotion and restoration of health. Miss Russell emphasizes the need for us to carry this spirit of collaboration into nursing education.

[1]E. Kathleen Russell — *The Report of a Study of Nursing Education in New Brunswick,* published by the University Press of New Brunswick, Ltd., Fredericton, N.B. 1956, p. 11.

Italy — 1957

Headquarters of the International Council of Nurses will be a hive of activity these days as plans for the ICN Congress in Rome, May 27 to June 1, 1957 are finalized. Application forms, approved by each National Nurses' Association, must be sent to the ICN by January 15. We have been granted an additional 20 places, making our total allocation 255. We expect all places will be taken.

In addition to the CNA delegates, the President and General Secretary, our Nursing Education secretary, Miss Frances McQuarrie will also attend the Congress. Following the meetings she will have an opportunity to visit some of the European countries and Great Britain where she will observe the programs of Nursing Education.

Into the Future Open a Better Way

Remember this phrase, you will hear it frequently from now till June 1958. You will hear and remember it long after that too, for it is the theme for our 50th Anniversary biennium.

Already plans are being made to assure that the path to the better way is being opened. National committees have set dates for their meetings in December and January; the CNA Executive meets in February; the Program Committee will also be outlining preliminary steps for what we expect to be a tremendous meeting in 1958. The CNA should be big news from now on. We'll all be asked questions about this our national association. Let's be sure we know the answers.

Remember — the CNA was founded on October 8, 1908 in Ottawa. The first president was Mary Agnes Snively. We became a member of the International Council of Nurses in 1909, the fourth country to join.

New Chairman

Not appointed at the time we referred to our new committee chairmen was Miss Margaret M. Wheeler, the chairman of the Committee on Public

Relations. Nursing consultant for the Ministry of Health, Division of Industrial Hygiene, Quebec, Miss Wheeler is an active member of her provincial association and has been, for the last few years, co-chairman of its Committee on Public Relations. We wish her and the members of the committee success in this biennium.

What's New from CNA?

LOAN FOLDERS ON ACCREDITATION

A limited number of loan folders on accreditation are available from National Office. They have been prepared mainly for the use of groups of nurses wishing to make a fuller study of accreditation procedures than is possible by using a Speaker's Kit. The loan period will be two weeks. It is suggested that, after reading the manuals and books in the loan folder, those interested in further study of any or all of them will purchase copies for their own libraries.

$64,000 QUESTION

Outline of a skit presented at the CNA Biennial Meeting, June, 1956. Patterned on the television show "$64,000 Question," it covers the following categories, the history, organization, literature, activities and international relationship of the CNA. For use by districts, chapters and other nursing groups, it is available on request, from National Office.

British Commonwealth and Empire Nurses War Memorial Scholarship

Applications are invited for a Sir James Knott Scholarship, administered by the British Commonwealth and Empire Nurses War Memorial Fund, of £350 sterling (approximately $875 Canadian) for the academic year 1957-1958. This scholarship has, in the past, been awarded to United Kingdom nurses having some connection with Northumberland or Durham but permission has been secured to offer one for 1957-1958 to a Canadian nurse. Applicants must, however, have some family connection with Northumberland or Durham, England. The scholarship is offered for postgraduate study in any aspect of nursing or midwifery outside of the applicant's own country.

Information regarding further qualifications required and conditions of award, as well as application forms, may be obtained from: The Canadian Nurses' Association, 270 Laurier Avenue West, Ottawa, Ontario.

Annual Meeting in New Brunswick

The New Brunswick Association of Registered Nurses observed its fortieth anniversary at the annual meeting held in Saint John on October 17—19, 1956. With Miss Grace Stevens presiding, Bishop Leverman opened the sessions by giving the invocation, while greetings from the city were extended by the mayor, Dr. G. B. Peat.

In her presidential address Miss Stevens paid tribute to the achievements of the past and to the founders of the association, which began its life in 1916 as the New Brunswick Association of Graduate Nurses with Mrs. W. S. Jones as its first president. Respect for the accomplishments of the past could be best displayed by catching from them a productive excitement for the future. Miss Stevens prophesied that the results of this meeting would give the nurses of the province every reason to believe that "Life begins at forty."

Out of the business sessions held on the first and third days arose these special points of interest:

A recommendation that private nursing rates should be increased from $8.00 to $10.00 daily, effective January 1, 1957 was approved.

A suggestion that a recommendation be sent to the head of the department concerned with Civil Defence requesting that a nurse representing the association be in on top level planning was accepted.

The report of the Advisory Committee to Schools of Nursing incorporated important recommendations related to

length of night duty terms, diet kitchen experience and clinical teaching programs — improvement in this area was felt to be of major importance.

A recommendation to raise the annual fee to $20.00 was approved. The work of the association is expanding and will expand further as a result of the research into and study of nursing in the province to date. To fulfill its responsibilities, the revenue made available to the association through an increase in fees is a vital necessity.

A recommendation that provision should be made for associate membership in the association with an annual fee of $6.00 was accepted. This fee includes the subscription to *The Canadian Nurse* and such a membership gives the holder freedom to vote at all meetings of the association and to hold office, except that of president or vice-president, in the chapter. Forthcoming revisions in the Act were made known to the members. A general meeting is to be called in regard to this matter.

Considerable concern was voiced in relation to legislation for the nursing assistant group. Long a subject of extensive study and thought, there was sincere regret that no decisive steps in this direction could be taken at present pending further study and revision of the Act of the association. It was hoped that definite action might be taken in the near future.

His Honor, Lieutenant-Governor D. MacLaren was a special guest of honor at the anniversary banquet and spoke briefly. Other guests of honor included six charter members: Mrs. W. S. Jones, Mrs. F. McKelvey, Mrs. J. Vaughan, Miss A. A. Burns, Miss A. Burns and Miss M. Murdock. During the course of the evening life memberships were presented to the charter members. Miss Lois Smith read the citations. Life memberships were granted to three charter members in absentia: Mrs. E. Hoyt, Mrs. D. C. Malcolm and Mrs. F. W. Munro. As a token of their affection for her and their appreciation of her devoted efforts on their behalf, the association members conferred an honorary membership upon Miss E. Kathleen Russell. The citation was read by Miss Katherine MacLaggan. Dr. Rae Chittick, the guest speaker, reviewed nursing activities of the past and presented the implications for the future in a most interesting address that is included in this issue.

A panel discussion "Toward Professional Maturity" left everyone mentally stimulated. Chaired by Miss MacLaggan, the panel was composed of Dr. Rae Chittick, Miss Helen McArthur, Miss Frances McQuarrie and Dr. Muriel Uprichard. Out of this extraordinarily able discussion of the nursing profession and its problems came several constructive suggestions for the future.

To Miss McArthur fell the difficult task of defining "nursing service." The ever-increasing numbers of personnel involved in the care of the individual patient made it difficult to clarify this service. Reference was made to the international code of ethics which defines it as "'a special service to this community, to this nation, to this world" but Miss McArthur offered also her own interpretation — "Nursing is the care of people that makes it possible to cure people." She referred most aptly to the "hump" over which nursing must climb to reach its highest objectives. Unanimously, panel members agreed that nursing is not meeting present needs.

Discussing the question of accreditation, Dr. Chittick pointed out that such a program helps the individual school to reach its objective and gives credit for attainment of *high* standards of education. Each profession should set up its own criteria but needs outside assistance in doing so. Authority is vested in those who set up the criteria. The program provides a counselling service which can assist a school in evaluating its total program. The public is given valuable information relative to the merits of various hospitals. Since accreditation is sought voluntarily, it indicates a willingness on the part of the school to develop beyond minimal standards. Accreditation methods are not standardized. Each school is judged on the basis of its own merits and philosophy, environment and problems. Some of the machinery of accreditation is already present in the work of nursing school advisers. This, however, tends to be a coercive program interested mainly in securing minimum rather than maximum standards.

Miss McQuarrie emphasized the place of the physical sciences in nursing education. They help to provide the fund of knowledge necessary for intelligent nursing. The usual error in our present system of nursing education is to give a smattering of knowledge in many areas forgetful of the importance of interrelationships. Physical function cannot be separated from the mind and emotional factors.

Dr. Uprichard stated that it was a sign

of maturity when a profession signified its willingness to seek outside assistance in solving its problems. To assist in this maturing process and, as a possible aid in assuming professional responsibilities, she offered the following suggestions:

There is a need for a change in the "psychological atmosphere" of nursing with nurses forming better lines of communication and becoming more vocal.

There is a need for a broad, liberalizing program of nursing education which would place more emphasis upon the humanities — literature, art, sociology, anthropology, etc. The present attitude that student nurses are in the school of nursing primarily for nursing service is traditional and unfortunate. The function of any school is education. Nursing education should be placed on the same basis as general education — in close contact with the hospital but not dependent upon it or obligated to it. Staff members must have a broad background of preparation. They cannot be expected to know everything but should "know enough to know when they *don't* know, and go and find out."

In summary, the panel members were in agreement that, to assist in the maturing process:

Independent schools should be developed as quickly as possible.

An effort should be made to conserve nursing power by a study of what nurses are doing that could be delegated to others.

Lines of communication up to the administrative level and reaching out to all with whom nurses come in contact should be improved.

Changes in nursing education programs should be instituted at an early date with full recognition of what it will mean to present staffs in terms of nursing load.

Accreditation programs should be given thoughtful consideration.

No matter what is done, much will depend upon the attainment of the proper emotional climate.

The report of the Committee on Nursing Education prepared and presented by Miss Katherine MacLaggan climaxed years of effort and, more specifically, a long year of intensive study of nursing in the province of New Brunswick by Dr. E. Kathleen Russell. Attention was focussed on "The Russell Report" and in particular on the recommendations embodied in it. It represents a significant milestone in the professional life of the association. Miss MacLaggan echoed the sense of urgency implicit in the recommendations when she advised immediate, earnest study of the Report by all chapters as one step towards implementation.

A gracious invitation by alumnae members of the General Hospital to attend a tea in the beautiful reception room of the new nurses' residence was enjoyed by all. Many of the guests availed themselves of the opportunity of seeing other areas in the residence through tours conducted by staff and alumnae members.

At the closing session Miss Grace Stevens, Miss Lois Smith, Mother Bujold and Sister M. MacKenzie were unanimously returned to office — a tribute to the capable leadership that they have given to their association.

JEAN E. MACGREGOR

Annual Meeting in Alberta

OVER THREE HUNDRED NURSES attended the annual provincial convention early in 1956 with "Better Nursing Through a Stronger Association" as their theme. The extent of individual contribution and participation was indicative of the desire that this objective should be realized. In keeping with the theme, the president, Miss E. Bietsch was concerned chiefly with the means by which the association might reach more of the membership and be of service to them. She reminded her listeners that the total membership, registered and associate, *is* the association and that the activities of the association depend upon what the membership wants and tells it to do.

Miss M. Pearl Stiver reviewed the aims and objectives of the CNA and emphasized that these can only be attained by working together and sharing ideas. She expressed the hope that, in the future, the secretaries in National Office, would find time and opportunity for more field visiting. The benefits derived by a school of nursing, by a

small hospital or by a chapter from the A.A.R.N. were discussed by various speakers. Mrs. Van Dusen presented a paper on "Membership — Lines of Communication" in which she stressed the importance of relaying information and the need for closer contact between the staff of provincial office and the membership at large to accomplish this. Miss H. Penhale outlined the need for curriculum study and more rigid inspection of schools of nursing with a view to better implementation of regulations.

Participation by the Student Nurses' Association was warmly welcomed. A comprehensive and interesting report of the activities of this group was presented by L. Nance, secretary. A resolution was adopted to hold the annual convention in Banff for the succeeding three years. In 1957, the meeting will be held May 28-31.

CLARA VAN DUSEN
Executive Secretary
Alberta Association
of Registered Nurses

Annual Meeting in Newfoundland

THE THIRD GENERAL MEETING of the Association of Registered Nurses of Newfoundland was held in October, 1956 at St. John's with approximately 100 nurses present.

Miss Elizabeth Summers, president, opened the meeting by welcoming the members.

Miss Janet Story, chairman of the finance committee presented the financial report which showed that the Association was in good standing. The president informed the members that the gavel used at this meeting was the one that had been presented by the CNA to the association at the convention in Banff in June 1954 to mark the entry of Newfoundland into the CNA as the 10th association member. She stated that the total provincial registration to date was 871 members with 621 active and 250 inactive members. Miss Summers then introduced the guest speaker Miss M. Pearl Stiver, who took as her theme, "The Canadian Nurses' Association, Its People, Its Purpose, Its Program."

In her address Miss Stiver said that the people of the CNA were its members who totaled 41,208 nurses. She mentioned the purpose and aims of the CNA. The first aim was the improvement of nursing education and nursing services. She explained that each national committee is composed of a chairman, appointed by the CNA executive committee, 10 members from the provinces — one from each province — and that this person is the chairman of the corresponding committee in her provincial association. She outlined the activities of these committees. The committee on nursing education has recommended that the CNA work out a program of evaluation of a few schools of nursing as a possible first step toward a program of accreditation of schools of nursing in Canada. Accreditation is on a voluntary basis and is aimed at maximum standards.

Another important objective of the CNA is the encouragement of an attitude of mutual understanding with nurses in other lands. To this end the CNA has membership in the International Council of Nurses. The ICN has a membership of 450,000 and links nurses from 37 countries. The CNA has affiliation with the World Health Organization through the ICN, the World Federation of Mental Health, and the International Hospital Federation. The CNA is working for progress in Canadian nursing.

Miss Stiver concluded her address with a quotation from an address given by Queen Elizabeth that may be applied to the commonwealth of nursing:

> "If we all go forward together with unwavering faith, high courage, and quiet heart, we shall be able to make this Commonwealth which we all love so dearly, an even grander thing — more free, more prosperous, more happy, and a more powerful influence for good in the world — than it has been in the days of our forefathers. To accomplish this we must give nothing less than the whole of ourselves."

A vote of thanks was given Miss Stiver by the vice-president, Miss Janet Story. The president presented Miss Stiver with a gift of a Labradorite bracelet. A reception was held following the meeting which gave the members an opportunity of meeting Miss Stiver personally.

LILLIAN B. COLEMAN
Chairman
Public Relations Committee

Le Nursing à travers le pays

Bonne et Heureuse Année!

En formulant ces souhaits, nous pensons aux infirmières des autres parties du globe et aux peuples qui vivent actuellement des heures d'angoisse et de souffrance dans les pays qui ne jouissent pas, comme le nôtre, de la liberté et de la paix. Prions et espérons que 1957 apporte à ces infirmières le courage nécessaire pour poursuivre l'oeuvre humanitaire du soin des malades et aux opprimés la force de supporter ces dures épreuves.

L'infirmière est partout réclamée et sa tâche est plus grande et plus difficile à mesure que la situation devient plus complexe.

Qu'en 1957, Dieu bénisse toutes les personnes qui se soucient de la santé et du bien-être de leurs semblables!

Des soins de qualité

"Améliorer la qualité des soins en nursing": voilà le thème de la conférence tenue sous les auspices de l'association des Infirmières enregistrées de l'Ontario, la première d'une série que se propose de donner le Comité du Service du Nursing. Plus de cent infirmières, représentant toutes les catégories du nursing, assistèrent à cette conférence.

Colloques, démonstrations, dramatisation, films, causeries et discussions en groupes contribuèrent à la variété du programme. Il y eut aussi variété parmi les participants: malades, membres de familles, psychiatres, psychologues, un dirigeant dans le domaine de l'éducation des adultes, des infirmières de toutes les catégories du nursing et à tous les échelons, ainsi que des auxiliaires en nursing.

Voici quelques-unes des pensées et idées présentées au cours des discussions de la semaine et qui expriment bien le ton général de la conférence:

> Les infirmières doivent apprendre à écouter avec un réel intérêt les problèmes des malades et ceux de leurs familles; elles doivent être conscientes des besoins de l'individu et apporter, pour leur solution, une attitude créatrice.
>
> Les infirmières doivent reconnaître le malade comme membre d'une famille et réaliser que lorsqu'un membre de la famille est malade, la famille entière est bouleversée et dans l'inquiétude.
>
> Le travailleur doit avoir un idéal; ses efforts doivent être reconnus et il doit se sentir désirable et important dans l'organization dont il fait partie; sa position et son prestige lui sont aussi importants que ses besoins physiques.
>
> Les mots et les actes ne reflètent pas que des idées mais aussi des sentiments et les gens sont aussi influencés par les sentiments que par les idées; "Ce qui compte ce n'est pas tant ce que l'on dit que la manière dont on le dit."
>
> Le groupement est une partie intégrante de la vie. La famille constitue un groupe et répond aux besoins fondamentaux de l'individu. C'est dans la famille que l'enfant apprend à vivre en société. Il est d'importance primordiale que dans chaque groupe les membres puissent se comprendre.
>
> L'autorité trop sévère provoque l'hostilité et l'agressivité. L'application de principes démocratiques s'est démontrée plus satisfaisante et plus efficace. Les gens s'offenseront des décisions arbitraires ou de changements dont ils ne comprennent pas la cause; au contraire, s'ils sont consultés et comprennent les raisons qui ont motivé les actes posés, ils coopéreront volontiers à la réalisation des buts proposés.
>
> Les infirmières ont besoin de s'intéresser à des activités en dehors de la profession si elles ne veulent pas devenir routinières et manquer de perspective. Vos activités sociales peuvent être un enrichissement pour la profession.
>
> Visez toujours plus haut. La plupart des gens pourraient faire beaucoup mieux qu'il ne font.
>
> "La bonté est la sagesse du monde." Si vous ne témoignez pas de bonté envers ceux qui vous entourent, ils seront, à leur tour, incapables d'en témoigner aux autres. "Rendre service, c'est le moyen de payer le loyer de notre habitation sur la terre."

Le rapport Russell

Un compte-rendu de l'assemblée annuelle de l'Association des Infirmières du Nouveau-Brunswick parait dans une autre partie de cette revue mais en parlant du nursing

à travers le Pays, il est impossible de ne pas mentionner le "Rapport d'une Etude sur l'Education des Infirmières" par Edith Kathleen Russell, I.E., présenté au cours de cette assemblée. Après une année d'étude intensive sur l'éducation en nursing dans les provinces maritimes, Mlle Russell a présenté une analyse qui a révélé des faits pouvant très bien s'appliquer aux autres provinces du Canada.

Bien que le projet ait eu pour but spécifique "d'étudier au Nouveau-Brunswick, les moyens à prendre pour réorganiser l'éducation des infirmières en vue de donner de meilleurs soins aux malades," l'on constate, dans le matériel qui a servi à cette étude, un examen attentif du nursing qui dépasse les frontières de cette province. Mlle Russell, dans la description du nursing de nos jours souligne les lacunes de notre système dans la formation de la majorité des infirmières. A la page 25 l'on trouve un exposé qui semble avoir été le thème qui a servi de base à l'étude et aux recommendations.

Les deux groupes — infirmières et groupes connexes — doivent maintenant être en mesure:

1. de fournir un exposé exact et détaillé des faits existants;
2. de rompre, au besoin, avec le passé lorsque cela s'impose.

La profession d'infirmière n'est pas seule pour envisager cette situation. Nos nombreux collèges des professions connexes dans le domaine de la santé, du bien-être et de l'éducation peuvent apporter leur contribution à faire reconnaître nos problèmes et à y apporter une solution. L'on comprend de plus en plus l'importance d'unir les efforts de toutes les disciplines tendant à un même but, en l'occurence la protection et la restauration de la santé. Mlle Russell insiste sur la nécessité d'enseigner aux infirmières cet esprit de collaboration.

[1]E. Kathleen Russell — Le Rapport d'une Etude sur l'éducation en Nursing, dans le Nouveau-Brunswick, publié par la University Press of New Brunswick, Ltd., Fredericton, N.B., 1956, p. 11.

Italie — 1957

Les quartiers généraux du Conseil International des Infirmières ressembleront à une ruche pendant ces jours où l'on mettra la dernière main à l'organisation du Congrès International des Infirmières devant avoir lieu à Rome du 27 mai au 1er juin 1957. Les demandes d'inscription, approuvées par chaque association nationale, doivent être envoyées au Conseil International avant le 15 janvier. L'on nous a accordé un surplus de 20 places, soit un total de 255. Nous nous attendons à ce que toutes les places soient occupées.

En plus des déléguées de l'A.I.C., la présidente et la secrétaire-générale, Mlle Frances McQuarrie, secrétaire du Comité national de l'éducation en nursing assistera aussi au Congrès. Après le Congrès, elle profitera de l'occasion pour visiter quelques pays d'Europe et la Grande-Bretagne et pour y observer les programmes d'éducation en nursing.

"Un meilleur chemin vers l'avenir"

Rappelons-nous bien cette phrase qui sera répétée fréquemment d'ici juin 1958, et encore longtemps après cette date. C'est le thème de notre 50ième Congrès Biennal.

Déjà des plans sont tracés pour l'ouverture de cette grande voie. Les comités nationaux ont décidé de se réunir en décembre et en janvier. Le comité exécutif se réunira en février; le comité du programme tracera une ébauche du programme de l'assemblée de 1958, nous y attendons une grande foule. L'A.I.C. occupera d'ici là les grosses manchettes. Beaucoup de questions nous seront posées au sujet de notre Association Nationale; assurons-nous de pouvoir y répondre.

Que l'on se rappelle bien — L'A.I.C. fut fondée le 8 octobre 1908 à Ottawa. Sa première présidente fut Mary Agnes Snively. L'A.I.C. devint membre du Conseil International des Infirmières en 1909; le Canada fut le quatrième pays à devenir membre de cet organisme international.

Qu'y a-t-il de nouveau à l'A.I.C?

Documentation sur l'accréditation, mise à la disposition des groupes d'infirmières qui désireraient faire une étude plus approfondie des procédés d'accréditation. Ces publications réunies dans une enveloppe sont prêtées pour une période de deux semaines à celles qui en font la demande. Celles qui, par la suite, seront intéressées à cette question et désireront l'étudier plus à fond, pourront acheter l'un ou l'autre de ces documents ou publications pour leur bibliothèque.

"La question de $64,000." Nous présentons le résumé d'une parodie du programme de télévision "La question de $64,000." Les questions portent sur l'histoire, l'organisation, les publications, l'activité et les relations

internationales de l'A.I.C. A l'usage des associations de districts, chapitres et autres groupes d'infirmières, ce travail peut être obtenu sur demande au Bureau National à Ottawa.

Bourses d'études

Une bourse d'étude de £350 sterling, (environ $875) offerte par le Fonds en mémoire des Infirmières du Commonwealth et de l'Empire Britannique qui ont participé à la guerre, pour l'année académique 1957-58. Cette bourse, dans le passé, était limitée aux infirmières du Royaume-Uni mais permission a été obtenue d'étendre cette offre aux infirmières canadiennes pour l'année académique 1957-58. Tous renseignements au sujet des conditions d'inscription à cette bourse d'études peuvent être obtenus en s'adressant à L'Association des Infirmières Canadiennes, 270 ouest, avenue Laurier, Ottawa, Ont.

Nouvelle convocatrice

Lorqu'il a été question des convocatrices des comités nationaux, Mlle Margaret M. Wheeler, convocatrice du Comité des Relations Extérieures n'était pas encore nommée; elle l'a été depuis ce temps. Mlle Wheeler est consultante en nursing auprès du Ministère de la Santé de la Province de Québec, section d'Hygiène Industrielle; elle est aussi très active dans son association provinciale, occupant depuis ces dernières années le poste de convocatrice conjointe du Comité des Relations Extérieures. Nous lui souhaitons, ainsi qu'aux membres du Comité, beaucoup de succès.

Sélection

MÈRE

Poème extrait de L'Enfant, revue éditée par L'Oeuvre Nationale de l'Enfance, Bruxelles, Belgique. Mai-juin 1955.

I

Ainsi, j'étais au fond de toi
Comme un peu d'eau tremblante
Dans un vase pur.
Ainsi tes yeux voyaient pour moi,
Ainsi tes pieds marchaient pour moi
Ainsi ta chair souffrait pour moi,
Ainsi tes pauvres mains
Lasses d'avoir lutté pour moi,
C'est sur moi que tu les croisais,
Et c'est avec ton sang
Que tu faisais battre mon coeur.
Ma mère,
Tu es bénie
Entre toutes les femmes.

II

Ainsi qu'une fleur
Lourde de rosée,
Ton sein se penchait
Et sous cette belle source
C'était déjà ton coeur
Que tu tendais à ma bouche
Il était toujours plein d'oiseaux
Et si mon vers chante parfois
C'est à ton lait que je le dois.

MAURICE CARÈME

Le coût des maladies mentales

Au Canada, le nombre des malades mentaux actuellement hospitalisés dépasse 62,000. Cela signifie que la proportion des habitants souffrant de troubles psychiques graves atteint 4 pour 1,000 et donc qu'il n'est guère de groupe familial, de collectivité, d'entreprise qui ne pâtisse directement ou indirectement de ce mal funeste entre tous.

Les dépenses exigées par l'entretien et le fonctionnement des cliniques psychiatriques sont passées, au Canada, d'un peu plus de 18 millions de dollars à près de 60 millions de dollars en 1952.

Mais le coût réel des maladies mentales est plus astronomique encore. Que l'on songe à la déperdition de travail productif qu'elles occasionnent non seulement chez les malades internés mais chez tous ceux (et ils se comptent par dizaines de milliers) qui sont plus ou moins gravement handicapés, dans leur vie privée et professionnelle, par des troubles d'ordre psychologique ou affectif: les névrosés, les alcooliques, les ratés, les instables, les insomniaques, les anxieux, les persécutés et tous les autres . . . Que l'on songe à l'étendue du mal qu'ils s'infligent à eux-mêmes et à autrui!

— Reva Gerstain, directeur du programme de l'Association canadienne pour l'Hygiène mentale.

A Wee Scrap of Humanity

MARION L. COPP

MISSED! But not forgotten — that tiny face still haunts us. That wee scrap of humanity that came to us many months ago, and in that time managed to completely win the affection and admiration of every nurse and doctor who cared for and watched over her in those first crucial days of life. Tiny Baby Cleo, one of the smallest babies to survive at Royal Victoria Hospital, Montreal, — 1 lb. 9 oz. — left our premature nursery weighing 5 lb. after four months of the most careful and loving care. We would like to tell you about her admirable progress.

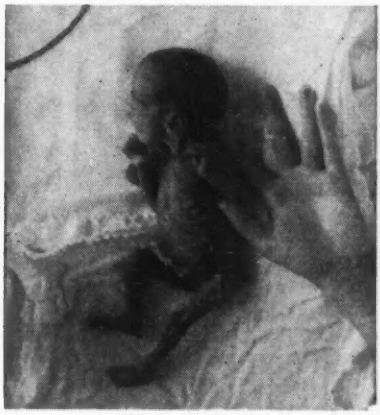
Cleo's mother was a severe eclamptic, and after several convulsive seizures the doctor's decision was to perform a Caesarean section. Thus, Cleo's entrance into the world came rather abruptly about 16 weeks ahead of time.

The baby was placed immediately in an incubator in the operating room. This special cot was carefully prepared for her reception, although we had little hope for the survival of an infant of this short gestation. But Cleo surprised us all as she breathed spontaneously, cried weakly, had little edema and no chest retraction. She was taken immediately to the premature nursery where she remained a good color and maintained fairly regular respiratory action in an incubator with high humidity and oxygen. A very accurate control over oxygen is very important in caring for small premature babies.

Forty per cent oxygen, reducing to 35 per cent, was used in the first 12 hours of Cleo's life. This was reduced gradually to 22 per cent over a period of six days. Oxygen was discontinued on her eighteenth day. Oxygen concentration, taken with an oxygen analyzer, is recorded every two hours for all babies receiving oxygen in incubators.

Premature babies are weighed only when we feel their condition is satisfactory, since minimum handling in their first few days is very important. They are turned from side to side very gently and not stimulated in any other way if their color is good and respiration is fairly regular.

Miss Copp is on the staff of the nurseries at the Royal Victoria Montreal Maternity Hospital, Montreal.



Cleo at Birth

Cleo was weighed when she was 48 hours old as her condition was good. One pound nine ounces was the first weight, which worried us as we thought of the ounces she had yet to lose. A very small amount of fluid was started at 50 hours — two cc. of five per cent glucose and water was fed to her by gavage with a number eight French catheter and funnel. This was continued at six-hour intervals for four feedings then every three hours from then on. On her third day we gave her diluted breast milk — 50 per cent breast milk and 50 per cent glucose and water — and she had her first interstitial — four cc. of 50 per cent normal saline and 2½ per cent glucose and water given slowly by syringe into her back. Small interstitials were given daily for two and a half weeks, the maximum amount being 10 cc. At this time Cleo took enough fluid by mouth to maintain adequate hydration. Her lowest weight, on the 9th day, was one pound five ounces (610 grams).

Cleo now took six cc. of breast milk every three hours. The next time

she was weighed a gain of ten grams was recorded and she was on her way up the scale. We weigh our babies every three days using a metric scale. Small gains were recorded on Cleo's chart from this time until discharge. Birth weight was reached at 28 days of age by which time she was taking nine cc. of milk each feeding. We increased her feedings very gradually during those first four weeks which were the most crucial and difficult of her life.

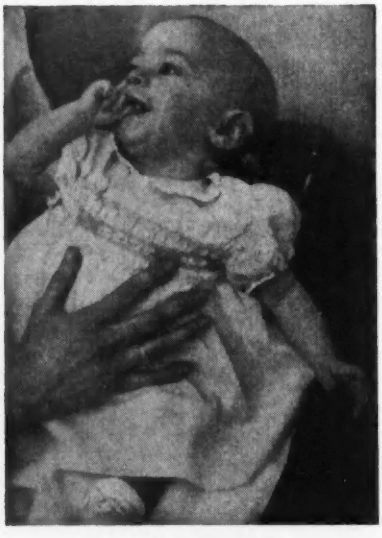
Two teaspoons of partly skimmed evaporated milk were added to four ounces of breast milk at six weeks of age to give the baby additional protein. We added more at a later date. At six weeks of age, Cleo weighed two pounds three ounces and was now classed as a baby in our medical records. She was taken out of her incubator for short periods once a day and carried about the nursery. A change in position and some tender loving care was felt a necessity in caring for a small baby who was being nursed continuously in an incubator.

Cleo had her first bottle, (Lundeen) a small one ounce bottle with a Breck nipple, at approximately seven weeks. She now weighed 2 lb. 5 oz. She sucked well and did not tire. She had sucked on the gavage tube since birth, sucking vigorously before her first bottle was offered. First we gave her one bottle a day, then one every eight hours, then alternated gavage and bottle before taking her off gavage completely.

Cleo was an exception because of her early bottle feeding; we rarely start bottle feedings before the babies are three pounds and then take them off gavage feedings gradually. Alternate feedings of breast milk and a partly skimmed evaporated formula (5 oz. milk, 15 oz. boiled water and 1 tablespoon of white sugar) were also started at this time. We knew Cleo's mother would not be able to nurse her so we felt she must become accustomed to partly skimmed milk a few weeks prior to discharge. Her gain in weight continued as the change was made over a period of one week. The strength of the formula was increased gradually until at discharge Cleo was on the formula we send most premature babies home on — 8 oz. partly skimmed evaporated milk, 12 oz. boiled water and 2 tablespoons white cane sugar. Cleo also had vitamin therapy, ascorbic acid 50 mgm. a day, which began at 6 days of age, and 1000 international units of vitamin D which began at 20 days of age.

Four pounds is graduation day in our nursery. Cleo at 12 weeks was moved to an open cot (with heat for a few days) was now picked up for feedings and fed every four hours rather than every three. Infants are not dressed until they have their incubators opened for feedings which is usually two or three weeks before they are transferred to open cots. At this time we also start the babies on normal newborn nursing nipples replacing

At Three and a Half-Months



Eight Months of Age

the Breck nipple. Ninety-five and 96 degrees F. were normal rectal temperatures readings for Cleo when she was very small. This changed to 97° — 98° at discharge. Her hemoglobin was noted every two weeks when the other babies were checked. Small blood transfusions are given to the premature babies if their progress appears to be hindered by a low hemoglobin. If, however, they are gaining and feeding well no transfusions need be given.

Cleo was 15 weeks old at discharge time (five pounds). She took three ounces of formula every four hours, followed objects slowly with her eyes, and slept through her night feedings. She stayed awake more during the day, possibly because she had extra attention. She had a very premature-looking head, flat on the sides but one didn't notice it too much, because her large brown eyes and long lashes were so appealing. Her eyes had been examined every week for signs of retrolental fibroplasia, beginning at five weeks, and were reported normal.

Cleo has been seen and examined since her discharge and appears very bright and normal in all respects. She smiles readily, sits up now at seven months of age weighs twelve pounds and has had no infection since discharge. A comparison of her measurements at birth and discharge show how much she grew in that three months period.

Head	— 9 in.	14 inches
Crown to rump	— 8¾ in.	12 inches
Crown to heel	— 13¼ in.	18 inches

Protein: the Stuff of Life

DON WINKS

THE "GREAT PROBLEM of modern chemistry" has been defined as the mystery of how the protein molecule — the fragile, stupendously complicated stuff which is the starting material for all life — is put together.

Why this should be so is indicated by two plain facts. These are: (1) that the further science penetrates into the chemistry of life, the more persistently it encounters the gigantic molecules that seem to contain the "essential operations" of living; and (2) that a full understanding of how these protein molecules are constructed will undoubtedly open the way to revolutionary new discoveries into the nature of life and death, health and disease.

Even in this era of burgeoning scientific discoveries, however, there is unanimous agreement that the solution to this problem is far from being just around the proverbial corner. The protein molecule is incomparably difficult to study. One researcher has suggested that protein, taken from the Greek "of first importance," should better have been named after the god Proteus, who was said to understand all the secrets of life, but who changed shape and fled whenever approached with a question.

But the enormous scope and complexity of the problem may itself hasten progress toward a solution by uniting scientists in all fields in a common purpose. The American Foundation, in *Medical Research: A Midcentury Survey*,[1] has suggested that just such a scientific blitzkreig may now be in the making, a full-scale assault on the mystery of the protein molecule.

Already known are many, if not all, of the vital life functions performed by protein in its various forms. Even an incomplete list would have to include that protein forms the hemoglobin which carries oxygen to the tissues; the antibodies and leukocytes which fight disease; the hormones and enzymes which regulate the life processes; all the body tissue; the sperm and ova that make reproduction possible; and the chromosomes and genes which control heredity.

Of necessity, the study of the protein molecule raises larger questions — questions concerning the origin and

This paper was supplied by Medical and Science Communications Associates, Inc., New York.

nature of life itself. How do living organisms make protein? How does protein — the nucleoproteins that control reproduction and growth — make living organisms? How did life begin in the first place? However it began, surely it must have begun with protein. But how?

Though the answer to these questions, which have haunted man since history began, may never be fully known, Dr. Stanley L. Miller[2] of the University of Chicago has provided an exciting experimental insight into how life may have been created under the conditions prevailing during the earth's infancy. Miller circulated methane, ammonia, water, and hydrogen — substances assumed to have preceded the organic compounds on which life is based — through a laboratory apparatus. Then he gave the circulating "muck" an electrical charge. He found, through paper chromatography, that two, and possibly more, amino acids had been created.

The significance of Miller's experiment lies in the fact that the amino acids are the basic material of protein. The production of even a few amino acids from inorganic materials (and Miller emphasizes he was attempting to duplicate primitive earth conditions, not to obtain maximum yield) suggests the possibility that life may have begun because of an "accidental" arrangement of amino acids into simple proteins.

Based on present knowledge, however, this possibility comes smack up against strong scientific objection. For one thing, so far as is now known, only a living cell can make protein from amino acids, hydrogen, nitrogen, oxygen, and other elements. For another, as Pierre Lecomte du Nouy[3] has pointed out in his classic work *Human Destiny,* such a sublime "accident" is contrary to all the mathematical laws of probability which are now accepted as the basis for scientific reasoning. But the fact remains that Miller created amino acids, the essential starting material of protein, from inorganic materials — and that amino acids never appear in a free state in nature, but only as constituents of the protein molecule.

Man has not yet succeeded in putting a protein molecule together, and has only with extreme difficulty succeeded in taking one apart. It took a team of British researchers 10 years to determine the structure of insulin, which turned out to have a molecular weight[4] of 5733.5, compared, for example, with ordinary table salt, with a molecular weight of 58. At that, insulin is preposterously small for a protein. Protein molecules are known with molecular weights in the millions.

But if size is characteristic of the protein molecule, so is complexity. As the English language is based on the 26 letters of the alphabet, all the infinite proteins of life are based on the twenty-odd amino acids. Since no two living organisms have exactly the same protein, the potential arrangements of amino acids into specific proteins must be astronomical. It has been calculated that the potential arrangements of lactoglobulin, with 370 amino acid residues of 20 different kinds, is on the order of 10_{425} — a truly astronomical number.

Of course there are molecules produced by living organisms which are just as gigantic as the protein molecule. Cellulose, for example, is enormous in size, but so stable that we can build houses out of it. The protein molecule, on the other hand, is so fragile that it can be affected by the absorption of a few quanta of light, with trifling changes in air pressure, oxygen concentration, temperature, or any of hundreds of other variables.

It is this fragile, almost evanescent, quality which seems to hold the potentiality of life, since life itself implies constant change, quick adjustments to altered conditions. But it is also this quality which makes the protein molecule so difficult to study. In fact, there seems no reason to believe that any individual protein can possibly be in its "native" state once it is separated from the living organism of which it is a part. The problem has been described by the editors of one textbook as follows:

> To attempt to equate the properties of a separated protein in a test-tube and those of a protein as part of a cell may well be like trying to study the economy of a modern industrialized society by observing how high the individual citizens thereof can jump.[5]

The analogy comparing a cell with a modern society is more than just

poetic. Dr. G. R. Cameron[6], the eminent British pathologist, has made it clear that the cell can no longer be considered, however superficially, as a more or less static "brick" from which are built all the tissues of the body. Instead, the cell is actually a miniscule society — say, a walled city.

The gates of the city consist of lipid molecules attached to fatty acids — from 3,000 to 300,000 of them to each cell — which act like swinging doors. But these doors are choosey about what they let in and out: viruses and proteins may storm the gates, or they may be invited in by phagocytosis. The cell has respiratory patches — a sort of "green belt" idea — and a pumping system to maintain its osmotic sovereignty. Once it was said that "a cell without a nucleus is a cell without a future,"[7] but Dr. Cameron states that the nucleus can be removed and a new one transplanted without adversely affecting the cell. So the cell can survive a change in "government."

Obviously, if scientists are to study the cell to learn its essential processes, they must find a way of penetrating the walls without halting the "economy." Dr. E. F. Gale[8] of Cambridge University has devised just such an espionage system: he disrupts the membrane of staphylococcal cells by shaking them at supersonic vibrations, then introduces radio-actively tagged amino acids into the ruptured cell and studies their fate.

In this experiment, Gale demonstrated that the incorporation of amino acids into certain proteins is dependent upon the presence of both ribonucleoprotein (RNA-protein) and desoxyribonucleo-protein (DNA-protein). The latter is the functional material of the genes, and it is inferred that the synthesis of a number of cellular proteins requires genetic control. The incorporation of amino acids into some other proteins was shown to be stimulated by the addition of only RNA-protein, which means that the synthesis of these proteins apparently does not require genetic intervention.

Amino Acid Packages

The raw materials for the construction of protein in the body are supplied in the diet. Dietary proteins are broken down (hydrolyzed)[9] to their constituent amino acids during digestion, and these amino acids are taken via the blood to the cells for endogenous synthesis; those not needed for construction may be metabolized for energy. If protein anabolism and catabolism are proceeding at equilibrium, the amount of nitrogen ingested (in dietary protein) will equal the amount of nitrogen lost in the urine, feces, perspiration, and shedding of outer skin. A positive balance, in which nitrogen is retained for growth or tissue building, is normal during childhood, in convalescence and in pregnancy.

A negative balance, on the other hand, may result from starvation, malnutrition, febrile diseases, and after burns and trauma. In this case the body draws first on its labile protein stores for the amino acids needed to maintain anabolism. Continued loss of nitrogen leads to wasting of the muscles, glands, and vital organs, placing life in peril unless the process can be reversed. Experiments at Rutgers University[10] have suggested that the body follows a priority order in raiding its protein stores; that is, those reserves that are depleted last are apparently filled first when dietary protein is again supplied.

All but eight of the known amino acids can be synthesized by the body from other sources. These eight essentials — leucine, methionine, phenylalanine, valine, lysine, isoleucine, threonine, and tryptophan — must be supplied in the diet. Nitrogen balance in adults can be maintained on a diet consisting solely of these eight amino acids. Conversely, if any one of these essentials is missing from the diet, a negative nitrogen balance results.

Not only must all the essential amino acids be supplied in adequate amounts, and in a balance suited to tissue synthesis, but they must be supplied approximately simultaneously. Rats fed a diet consisting of all the essentials but one — in some experiments tryptophan, in others methionine or lysine — could not maintain growth if the missing amino acid was fed several hours after the incomplete mixture.

Proteins are thus packages of amino

acids, with the biological value of a given protein depending directly on the single essential amino acid in shortest supply. In general, animal products contain high quality proteins, while wheat, maize, and rice protein are of poor quality; that is, they are much less effective than animal proteins in maintaining nitrogen balance or promoting growth. However, by adding a synthetic amino acid to a protein deficient in one or another of the essentials — lysine to wheat gluten or lysine and tryptophan to maize — such low-cost proteins can be converted into proteins comparable in biological value to milk or meat.

This Too, Too Solid Flesh

Hamlet's lament "this too, too solid flesh" reflects a picture of the living organism which has only in recent years been drastically revised. Once the amino acids were conceived of as the "building blocks" of protein. Proteins were the "building blocks" of tissue. And tissue was the "solid flesh." Experiments with radioactive isotopes have revealed a picture as different from this as a motion picture is from a still photograph. The living organism, it was found,[11] is forever in a state of rapid flux.

For example, when researchers fed fatty acids labelled with deuterium to laboratory animals, they found that a large proportion of the tagged material rapidly appeared in fat deposits all over the body. When the isotope was administered in one particular fatty acid, the deuterium was distributed over nearly all the other acids found in body fat. Isotopic carbon fed in the form of sugar appeared in body protein and fat, as well as carbohydrates.

These and other experiments have made it clear that all the complex molecules of the body are constantly involved in rapid chemical reactions. Ester, peptide, and other linkages open, fragments are liberated and merge with those derived from other large molecules. Some fatty acids are completely degraded, while other molecules of the same chemical species are steadily being formed from other substances, notably carbohydrates. Amino acids are deaminated and the liberated nitrogen transferred to previously deaminated molecules to form new amino acids. By other metabolic pathways the amino acids or their deamination products can be converted to carbohydrate, fat or nucleic acid.

This dynamic chemical activity is not restricted to the relatively small amino acid molecules. Indeed, many studies have demonstrated that macromolecules, the proteins so essential for cellular structure and function, are themselves in a constant state of breakdown and resynthesis. Through the use of radioisotopes, it has been estimated that one half of the total body protein of a normal adult man is degraded and rebuilt every 80 days ("half-life" = 80 days.) On this basis it may be calculated that about 90 grams of protein must be resynthesized from the amino acids each day simply to maintain the protein stores of the adult body. Furthermore, some of the proteins are much more labile than others. The "half-life" of blood plasma and liver proteins, for example, has been estimated to be only 10 days. This means that such proteins must be resynthesized at about eight times the rate estimated for total body protein.

The extraordinary fluidity of all the molecules of the body prompted British scientist, J. W. Cornforth[12] to compare life to a reversible chemical reaction. The reaction may in balance be proceeding in one direction, but at any moment there are some molecules going the other way. If equilibrium is reached, it is only because the opposing reactions are proceeding at the same speed.

A New Theory of Life

One thing seems manifestly clear as our knowledge of the most intricate functions of life increases: that we are proceeding from complexity to greater complexity, with many "fundamental" biological ground rules being broken in the process and new, if shaky, ones being laid down to take their place. What is needed, ideally, is something comparable to Einstein's theory of relativity, something that would hold as a framework for the total system of all living things, to which all observational data could be related.

As of now, a concept which started

some 20 years ago — the need for transferring research emphasis from chemical analysis to organization, from isolated reactions to total systems — is stirring the field. The goal: an electrodynamic theory of life, in which the characteristic relationship of the elements of any single biological system is but a function in the dynamic field of the total system.

Such a theory may, however, be a long time building. As the American Foundation has pointed out, the problem of biological organization "remains our greatest area of ignorance." The problem may await the conceptual genius of a Newton or an Einstein, who will organize biology into a theoretical system which will reveal gaps in current knowledge, suggest profitable paths for research, and make it possible to anticipate future developments in the science of life.

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Book Reviews

You and Your Retarded Child by Samuel A. Kirk, Ph.D., Merle B. Karnes, Ed.D. and Winnifred D. Kirk, M.S. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto, Ont. 184 pages. 1955. Price $4.00.

Reviewed by Miss Dorothy Marcellus, 92 College Street, Toronto, Ont.

This manual discusses two very important aspects of retardation: the parents' acceptance and realization of this condition, and the methods by which the retarded child may be taught to help himself and eventually either become acceptable to society or be placed in institutional care.

The explanation of retardation is very clearly stated and should clarify questions for parents and teachers who are attempting to determine the present and potential levels of development. The stress on readiness for training and teaching is very well explained. The concise description of the various functions of each specialist should clarify for parents the apparently conflicting reports regarding their child's condition. The chapter dealing with the relative amount of retardation could be dangerous information to give to parents. It is essential to have parents understand levels of retardation in accordance with level of development, but this table could, to the parent of a "totally dependent child," discourage them to the point of rejection long before a vacancy was available in an institution suitable for his care. In giving this manual to the parent of such a child, it is felt that it would be well to have this done by the psychologist, but only when he decides that the parent is ready to accept this information. Otherwise, the remainder of the valuable informa-

tion in this manual will be lost.

The next seven chapters dealing with "Helping Your Child to Help Himself" are excellent. The small details of consistently establishing routines such as dressing, feeding, sleeping, play habits, etc., are written exceptionally well with the keen understanding of the child's needs and the right approach for each routine or habit. The development of language comprehension, speech and the baffling problems of behavior and discipline, illustrate the sympathetic understanding needed in establishing communication and maintaining control of retarded children and in their eventual acceptance into the appropriate group — educable, trainable, or totally dependent.

The last chapter "A Total Program for the Retarded" is based, of course, on facilities and needs for them existing in the United States, although the development of schools or institutions for the retarded is very similar in Canada. Whether Canada is ready to accept a federal program such as outlined in this text is considered to be a matter for debate.

This manual should be an invaluable reference and guidance text for physicians, teachers, therapists, nurses and social workers in understanding and assisting retarded children to mature to the limits of their mental and physical abilities.

Hands to the Needy — Mother d'Youville, Apostle of the Poor, by Sister Mary Pauline Fitts, G.N.S.H., Doubleday and Co. Inc., Garden City, N.Y. 1950.
Prepared by Miss Claudette Carrière, second year student, St. Elizabeth School of Nursing, Sudbury, Ontario.

This is a powerful biography of Mother d'Youville, the foundress of the Canadian order of Grey Nuns.

Marie Marguerite Dufrost de Lajemmerais was born at Varennes, Quebec, in 1701. Her father died seven years later leaving her mother with five children to care for. In 1712 Marguerite entered the Ursulines' Boarding School in Quebec. She only received two years of formal schooling but for these she was very thankful. She returned home to help her mother. Marguerite developed a charming personality, a graceful courtesy, a great piety, and an intense charity for the poor and the sick whom she visited on every possible occasion.

After moving to Montreal with her family in 1722, she entered new social activities and met the handsome François d'Youville whom she married. Unfortunately, she soon dis-

covered that he was crude, selfish, indifferent, and good for nothing. Though disappointed, she never wavered in her duty to him, nor in her efforts to please him. She gave birth to five children. Only two boys survived who later became priests. After eight years of tragic marriage, François d'Youville died leaving Marguerite penniless, with heavy debts. By daily toil she covered her husband's debts then resolved to spend her life in alleviating human suffering.

In 1737, when the hard times seemed over, Mrs. d'Youville decided to take a few destitute persons to live with her in her own home. As time went on, more abandoned and homeless aged were accepted. Three companions joined her and from then on, most of their income came from charity. In spare time they increased their earnings by needle-work of all kinds. This home was the cradle of the Congregation of the Sisters of Charity or Grey Nuns. From it they launched a new program of caring for the sick in their own homes.

Sufferings and trials had not been spared Marguerite as a girl, a wife, a widow. They were still to accompany her as a Foundress. One January morning in 1745, she awoke to the cries, "Fire! Fire!" All her poor were brought to safety, but nothing else was saved. The tragic incident did not daunt Mrs. d'Youville and her companions. Thanks to their confidence in Divine Providence, to their initiative, and to the help of generous patrons, their project was soon reestablished.

Meanwhile, the General Hospital of Ville Marie was falling into ruins. Bishop Pontbriand, well aware of Mrs. d'Youville's administrative abilities, urged her to take over. Although she was just recovering from a severe illness, she accepted. Women and carpenters worked strenuously to restore the edifice. The remarkable transformation permitted the Sisters to accommodate more patients. Rich persons demanded the privilege of boarding there. These paying boarders and their needlework provided considerable revenue.

For nearly eighteen years, Mother d'Youville and her associates had been called les Soeurs Grises — a name sprung from malice and mockery. She decided to retain this name but to give it a new and beautiful meaning. She designed the costume that the sisters would henceforth wear. She outlined the rules to which they and the generations

of Grey Nuns since have bound themselves. Then, in grateful rememberance of Louis XV, King of France, by whom she had been granted the letters patent that sanctioned the Community in 1755, she decided that the Sisters' Crucifixes should be adorned with Fleur-de-Lis.

During the Seven Years War, the hospital still served as a refuge for the needy. The English were also treated there, for Mother d'Youville's love knew no nationality. Such charity saved the hospital from being bombarded. On September 7, 1758, General Amherst, taking the hospital to be a fort, ordered its destruction. But a soldier who had been treated there begged the commander to spare it.

Following this war, poverty became extreme since most of the wealthy patrons returned to France. However, the Sisters of Charity placed their trust in Divine Providence who protected them in a tangible way. Among other gifts they received several barrels of fine flour at a time when the very grains of wheat were being counted.

The year 1764 was, on the whole, comparatively hopeful for the General Hospital. Then merciless flames turned it to ashes. Sisters and patients were sheltered while the hospital was being restored.

As the autumn of 1771 came to a close, the Sisters noticed a gradual change in Mother d'Youville. Her spirit seemed to be losing its strength, her step was often unsteady, her speech became slow and uncertain. In December a stroke paralyzed her left side leaving her speechless. Another stroke on December 23 proved fatal.

As a dutiful wife, a devoted mother, a perfect religious, Marguerite d'Youville was indeed daughter of the Eternal Father.

Introduction to Operating Room Technique, by Edith Cornelia Berry, R.N., A.B. and Mary Louise Kohn, A.B., R.N., M.N. McGraw-Hill Company of Canada Limited, 253 Spadina Road, Toronto 4. 1956. Price $4.20.

Reviewed by Miss Muriel Ward, 383 Sherbourne Street, Apt. 23, Toronto, Ont.

This soft bound manual has perforated punched pages which facilitate incorporation with local routines. The concise contents are presented in an interesting manner easily understood by the student nurse. The introduction discusses opportunities and objectives, construction and organization of an operating room.

The principles of technique, discussed in terms applicable to any situation, are organized under: Sterilization, Asepsis and the Principles of Sterile Technique, The Surgical Scrub, Gowning and Gloving, Positions, Preparation of the Patient's Skin, Draping, Room and Table Set-up, Procedure of a Case, Methods of Hemostasis, Sutures, Needles. Where illustrations enhance the text, clear sketches are accompanied by excellent descriptions. "Procedure of Case" is printed in two column style as is the entire manual. The left column describes the circulating nurse's activities and responsibilities while the right one outlines those of the scrub nurse, the context being set so that these are parallel in time. When specific procedures are outlined in order to emphasize principles one notes such comments as: "Draping procedures vary from one operating room to another. However, a standardized method of application should be practised in each one . . . The most common ones are discussed here merely to demonstrate the principles."

A brief history provides background for specific area topics — Radium, plastic surgery, orthopedics, urology, ophthalmology and otolaryngology. Concise definitions are logically grouped — e.g. extraocular and intraocular eye surgery. Careful handling and maintenance of equipment is described. While information about instruments such as care and handling, sterilization and storage, is located in pertinent chapters, this reviewer feels that a chapter centralizing this topic would provide a more forceful presentation. Surgical equipment, wound healing, anesthesia, medicolegal aspects and economy complete the material offered in this manual.

A complete bibliography and alphabetical index are included.

* * *

Many of the best decisions are arrived at by people while they are taking long walks. We do very little walking these days; and that may account for many of our unwise decisions.

Nursing Sisters' Association

THE 15TH BIENNIAL SESSION was held in the auditorium of St. Boniface Hospital, Winnipeg, late in June. Mrs. L. Rabson, national president, was in charge of proceedings. In her address, Mrs. Rabson noted that Edmonton, the oldest unit, had celebrated its 35th anniversary last year while Montreal had reached its 35th year at the present time. The national association came

into being in Montreal in 1929 with the coalition of ten units.

One of the most important matters for discussion was the Agnes C. Neill Memorial Fund. Initiated through a bequest in Miss Neill's will, it has been a matter of concern to the various units that a decision should be reached that would provide for the most suitable disposition of this fund. Donations have increased the amount on hand. After careful consideration and discussion of various proposals and objections, the membership voted that the fund should be used for educational purposes with the CNA assisting in regard to administration and distribution. To this end the incoming executive was commissioned to set up a committee responsible for the fund. It was foreseen that a fund used for such a worthwhile purpose could become a fitting memorial not only to Miss Neill but to the association membership as a whole.

A special tribute was paid to Mrs. C. A. Young, Ottawa. Although unable to attend association meetings, she faithfully attends each year to the placing of the wreath for the national association on the National War Memorial at Remembrance Day observances. Other reports indicated the very worthwhile projects with which individual units have been associated and plans were made to maintain the useful nature of the association both as regards its own membership and the community.

* * *

True merit is like a river, the deeper it is the less noise it makes.

British Columbia

The following are staff changes in the Metropolitan Health Services:

Appointments — *Eve Anderson* (McGill Univ.), *Mrs. Mary (Hawkins) Baigent* (U.B.C.), *Mrs. Glen Baker* (U.B.C.), *Mrs. Margaret Braddick* (Calgary Gen. Hosp.), *Lorna Calderwood* (Univ. of Toronto), *Mrs. Shirley Cooper* (U.B.C.), *Lily Dong* (U.B.C.), *Emily Doree* (U.B.C.), *C. Dossetor* (Sanitary Institute of London), *Vera Freeman* (U.B.C.), *Helen Gray* (U.B.C.), *Mary Ann Hart* (Univ. of Alta.), *Mrs. Catherine Huene* (Univ. of West. Ont.), *Marjorie Long* (U.B.C.), *Donna Mawhinney* (U.B.C.), *Pat Mitton* (U.B.C.), *Rosemary Stalker* (U.B.C.), *Mrs. Beryl Sussel* (U.B.C.), *Frances Thompson* (Univ. of Alta.), *Mrs. Edna (Howard) Tretheway* (U.B.C.), *Mrs. Jean Watts* (U.B.C.), *Helen Wray*

(U.B.C.), *Mrs. Jean Wright* (Univ. of Alta.).

Resignations — *Mrs. Isobel (Angus) Abercrombie, Miss Judith Bowlby, Mrs. Josephine Contini, Miss Aileen Colcleugh, Miss Joan Crawford, Miss Nellie Fisher-Davies, Mrs. Jean Hardie, Mrs. Henrietta (Shipley) Holmes, Miss E. Leighton, Miss Kathleen MacDonald, Miss Jean McMurray, Miss Marjorie McLaughlin, Mrs. Gwen (McPherson) Proust, Miss Margaret Stewart, Mrs. Gerda (Murray) Todd, Mrs. June (Dawson) Wick, Mrs. Anita Wong.*

* * *

A friend is one who sees through you and enjoys the side show.

Ontario

The following are staff changes in the Ontario Public Health Nursing Services:

Appointments — *Mary (Rust) Moore* (Toronto Gen. Hosp., Univ. of Toronto), *Julia (Dunn) Liphardt* (T.G.H., U. of T.) formerly with Halton Co. Health Unit, *Patricia Stevens* (Hamilton Gen. Hosp., U. of West. Ont.) and *Lois (Eddy) Suggitt* (Ottawa Civic Hosp., U. of T.) to Etobicoke Township Board of Health. *Joan Cormack* (Hosp. for Sick Children, U. of T.) formerly of Bruce Co. H.U. to Haliburton Co. School Health Service. *Beatrice Mair* (P. E.I. Hosp., Charlottetown, McGill Univ.) to the Halton Co. H.U. *Liv-Ellen Lockeberg* (Royal Vic. Hosp., Montreal, U. of T.) to Kent Co. H.U. *Doreen Appleton* (Kingston Gen. Hosp., Queen's Univ.) to Lennox and Addington H.U. *Judith Bowlby* (Women's College Hosp., U. of T.) to Muskoka District H.U. *Helen Etherington* (St. Catharines Gen. Hosp., U. of T.) to the position of senior public health nurse, Peterborough B.H. *Agnes (Thomson) Somerville* (St. Jos. Hosp., London, U. of West. Ont.) to Strathroy B.H. *Elizabeth (Wilson) Charsley* (Toronto East Gen. Hosp., U. of T.) to Sudbury and District H.U. *Patricia (Jackson) Proud* (Toronto West. Hosp., U. of T.) formerly with Peterborough B. of H. to Toronto Dept. of P.H. *Ruth (Stuart) Ferguson* (Hamilton Gen. Hosp., Queen's Univ.) and *Ellen (Fuller) Pepper* (Toronto West. Hosp., U. of T.) to Welland and District H.U.

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Silo—Filler's Disease

Farmers have long known that it is dangerous to enter a newly-filled silo, but few realize the full extent of the danger. A serious and potentially fatal respiratory disorder can result from breathing the gas of fermenting silage.

The newly-identified disease is described as "any bronchial or pulmonary condition produced by the inhalation of oxides of nitrogen derived from fresh silage." Because it resembles other lung conditions, such as bronchopneumonia, the doctor must know the patient has been exposed to silage fumes before he can make the proper diagnosis. The possibility of exposure to nitrogen dioxide fumes may increase because of the greater use of commercial chemicals containing nitrogen. These are likely to increase production of nitrogen dioxide in silage.

Prevention of the disease is simple. "Allow no one to enter a silo for any purpose from the time filling begins until seven to 10 days after it is finished." Nitrogen dioxide fumes are produced during this period. In addition, good ventilation about the base

of the silo should be provided during the dangerous period so that gases will be carried away. The area should be fenced to prevent children and animals from straying into it, and a blower fan should always be run before anyone enters a silo.

The disease follows a pattern. Immediately after exposure, a cough, difficulty in breathing, a choking sensation and severe weakness occur. These symptoms remain to some degree for about three weeks when the second phase of the illness begins. The symptoms become progressively worse. Chills, fever and blueness of the skin appear. Eventually bronchiolitis fibrose obliterans occurs. In this condition the tiny air sacs of the lungs become closed by the ingrowth of the wall tissue.

Antibiotics and other standard treatments for respiratory diseases have no effect on the symptoms. Two cases were treated successfully with prednisone, a hormone related to hydrocortisone. Two other reported cases which showed different but related symptoms suggest that silo-filler's disease is a "continuous spectrum of conditions." The manifestations are likely to differ widely, while severity depends upon the concentration of nitrogen dioxide inhaled and the duration of exposure.

— *The Health Bulletin*, North Carolina

News Notes

ALBERTA

District 4

Medicine Hat

General Hospital

Thelma E. Heine was the recipient of *The Canadian Nurse* award for the student showing the greatest promise of professional development at the end of her first year of training. Thelma, who has wanted to be a nurse for as long as she can remember, is presently secretary of the Student Nurses' Association and is working diligently toward her professional goal.

District 8

Lethbridge

One hundred members enjoyed the annual banquet in October of last year. A message

of greeting was received from Miss Bietsch and Mrs. Clara Van Dusen attended the dinner as one of the guest speakers. Mmes Michael, Gooder, Howe and Miss Shorrt presented a most informative panel discussion on community service. In November, 45 members attended the regular meeting. Miss Monteith reported on the council meeting held in Edmonton. Mmes Jacobson, Melch and McKenzie presented additional aspects of community nursing service.

BRITISH COLUMBIA

VANCOUVER

St. Paul's Hospital

The annual homecoming held in October was a gala occasion with 210 alumnae registering. Honored guests and sisters increased total numbers. Sister M. Loyola and Mrs. G. Collishaw welcomed the nurses. Members of the classes of '21 and '22 were special guests. A short program which included a comic fashion show, with Mrs. G. McKenzie as commentator, was followed by a tea at which everyone indulged in large quantities of talk as well as good food. In 1957 guests of honor will be the classes of '23 and '24. Members of these classes or anyone knowing their names or addresses are asked to get in touch with Mrs. Goodman, 1430 Maple St., Vancouver, B.C.

Miss Penny and Mrs. J. (Hamilton) Watts have successfully completed postgraduate study at U.B.C. Presently attending the university are: H. Lietz, K. Kopp, A. Gibson, P. Palmer, N. McCardle, J. Nakamoto, S. Tomon, J. Harmsen, M. Launer, M. Brown. R. Blodgett is on the staff of Kitimat Hospital. D. Wardill is working at the Grey Nun's Hospital, Regina. R. Smith has returned after field work in Boston, Montreal and Toronto. J. Smalley returned recently following a year in Bermuda. M. Brown has gone to Pakistan as a member of WHO. Mrs. Rider, Mrs. Lee, M. (Smyth) Toner, J. Perkins and E. Storm are all on the staff of St. John's Hospital, Santa Monica. E. O'Neill and M. T. Kelly are employed at Miami Beach, Florida.

In October, Hazel Hull was the guest speaker at the meeting and showed pictures and slides of a holiday trip to California. Mrs. B. Gatti, president of the local branch of CARE was guest speaker at the November meeting and outlined the work of this energetic organization.

VICTORIA

The final meeting of the chapter for the year 1956 took the form of a most enjoyable dinner meeting held at the Oak Bay Beach Hotel and convened by Miss B. Davis. At a short business meeting after dinner, reports were given by Mrs. A. Ault, convener of the committee on Future Nurses' Clubs; Miss E. Riddell on the last R.N.A.B.C. Council meeting; and Miss J. Jamieson on a meeting of the Unitarian Service Committee at which Dr. Hitschmanova told of her work for the

underprivileged in other countries. The highlight of the evening was a most interesting, amusing and thought-provoking address by Miss Mary Richmond, who talked of her experiences while in New York attending Columbia University to obtain her master's degree.

NOVA SCOTIA

KENTVILLE

Mrs. Margaret Boehmer was recently appointed superintendent of the Blanchard Fraser Memorial Hospital. An At Home was held at the nurses' residence under the auspices of the senior and junior Ladies Auxiliaries to welcome Mrs. Boehmer to her new position.

ONTARIO

DISTRICT 2

SIMCOE

After almost 50 years of service, Agnes Sophia Herron is still actively engaged in nursing. Miss Herron began her training at the North College Avenue Hospital in Philadelphia in 1906. This institution was operated by women doctors for women and was one of the first hospitals to be established on the continent after the Crimean War. Miss Herron completed her professional training at the Polyclinic Hospital, Philadelphia. She began her career at a time when private nursing was a luxury which few could afford. Much in demand by the doctors of her day because of her skill in bedside nursing, Miss Herron has, for the past 12 years, devoted her attention exclusively to the care of a gentleman injured 22 years ago in an explosion. To him, this petite, agile little lady symbolizes all that a good nurse can and should be.

DISTRICT 5

TORONTO

General Hospital

The past year saw many class reunions with their accompanying oportunity for renewing friendships and exchanging latest news of alumnae. The classes of '23, '26, Spring '46, September '22, Spring '45, September '21, '30 and '52 enjoyed such occasions. A group of T.G.H. graduates in North Bay, representing various graduation classes, had dinner together and gleaned the following news items. S. (Ostler) Cooper is on the staff of the North Bay Civic Hospital. G. (Gladback) Rawn is engaged in part-time public health nursing. F. (Gasson) Eyalfson is also on the staff of the Civic Hospital.

D. Dix has resigned from her position as assistant inspector of nursing schools in Ontario to join the staff of the school of nursing, University of Western Ontario. H. MacLennan is on the staff of the Sunnyview

School for Crippled Children. P. Batt is with the N.B. Dept. of Health and Social Services. B. Sauder is attending the University of Western Ontario. J. Stanko is working in San Francisco; L. Prihodko is in Marathon, Ont., and M. Booth is in Vancouver. F/O. M. Keenan is stationed at the R.C.A.F. station, Chatham, N.B. Helen Marie Kennedy was the recipient of a bursary given annually by the Red Cross Society. She will study public health nursing at the University of Manitoba, returning subsequently as a member of the Outpost Hospital staff of the Ontario division. H. McLaren has returned to her home school after completing postgraduate study at the University of Western Ontario. R. A. Cross and A. Nemerosky have also returned following study at the same university. L. Fukomoto has been appointed assistant head nurse after completion of her course at the University of Toronto. I. Kravenchuk is attending U. of T. this fall.

Interesting reports of their activities have been received from London, Brampton, Oakville and Hamilton chapters.

Hospital for Sick Children

A stained glass window in the hospital chapel, dedicated by Rt. Rev. F. H. Wilkinson, Bishop of Toronto, honors the pioneer work of four women who established the school of nursing. Mrs. Hannah (Cody) Grant, a graduate of the Toronto General Hospital, served this hospital and school from 1886 to 1891 as its first superintendent of nurses. Mrs. Grant died in 1947 at the age of 92. Sarah Annie Kinder, a graduate of the New York Polyclinic, was appointed the first instructor in 1906. She was one of the first nurses in Canada to hold such a position. In 1913 she was appointed assistant superintendent of nurses — a position she held until 1921. Miss Kinder died in 1935.

Mrs. Louise (Brent) Goodson, a graduate of Brooklyn City Hospital, New York, served as superintendent of nurses for 17 years until her marriage. It was during her term of office that the hospital first began to gain its national reputation. Florence Potts came to the staff in 1903 as a young graduate of the Lady Stanley Institute, Ottawa, and of Teachers College, Columbia University. She served the hospital in various administrative capacities until becoming the superintendent in 1913. After nine years of successful work in this position, she resigned to become director of nursing service in the Shriners Hospitals for Crippled Children.

PRINCE EDWARD ISLAND

CHARLOTTETOWN

A meeting of the Association of Nurses of Prince Edward Island was held at the Prince Edward Island Hospital nurses' residence in November, 1956. The president of the association, Miss Ruth Ross, presided and the meeting was well attended. The business part of the meeting was concerned with the discussion of personnel policies for nurses as presented by the Nursing Service Committee under the chairmanship of Sister M. Patricia. These policies with a few changes were adopted by the membership.

The remainder of the meeting was devoted to the presentation of a play entitled, "New Fountains" by Lee Gilmore, written for the American National Foundation for Infantile Paralysis. The play directed by Sister M. Irene, had the following cast: G. Seaman, B. Gillis, B. A. Gallant, J. Paquet and H. Creed — all students of nursing at the Charlottetown Hospital. The play portrayed the problems faced by a high school girl who has residual paralysis as a result of poliomyelitis. It emphasized the need in such cases for understanding guidance and support from parents and classmates. The moods and attitudes of the

characters were caught by the cast and depicted with sensitivity.

An annual district meeting of the nurses association was held at the Red Cross House in October, 1956. Seventy nurses, including a large representation from the Summerside district, were present. Miss Ruth Ross was chairman.

Miss Helen McArthur, national director of Canadian Red Cross nursing was guest speaker. In an illustrated talk, Miss McArthur dramatically portrayed the philosophy, differences and similarities of the Korean way of life as compared with ours. The courage of the people under extreme hardship, their love of freedom and their deep devotion to their culture and traditions make us realize that this is not "an underdeveloped country" in the true sense of the word. The Koreans have not been able to feed their physical bodies properly but they have fed their minds and souls well during the long seige of hardship.

Charlottetown Hospital

The students were privileged to have Miss Elizabeth Reid as their guest speaker at a recent meeting of the Students' Council. Miss Reid is an Australian-born journalist and a member of the International Grail Movement. She has spent the past seven years in the Far East and has covered many important stories such as the Korean prisoner of war exchange and the siege of Dien Bien Phu. She is currently on a speaking tour of Canada and the United States.

Miss Reid discussed in some detail three areas of Asia — Hong Kong, Korea and Vietnam where there are large concentrations of refugees from Red dictatorship. These refugees whether they fled for political, economic or religious reasons, left all their possessions in order to get freedom. The conduct of these people is a great challenge to us. She asked the students to consider the possibilities of using their nursing skills to help the Asian people.

QUEBEC

Instructors' Group

This is to introduce the Instructors' Group which is a sub-committee of the School of Nursing committee of the A.N.P.Q. It is composed of members from the English-speaking hospitals of the province of Quebec.

Executive officers for 1956-57 are: Chairman, M. Gallivan, St. Mary's Hosp.; Vice-Chairman, Mrs. N. Franklin, Montreal Children's Hosp.; Secretary-Treasurer, L. Duggan, St. Mary's Hosp.; Members of Executive, F. Bryant (Past Chairman), Queen Elizabeth Hosp.; B. Kuhn, Royal Edward Laurentian Hosp., M. Blacklock, Royal Edward Laurentian Hosp., A. Christie, Montreal General Hospital.

A general meeting was held in October, 1956 at the Y.W.C.A. There was a short business meeting, followed by individual self-introduction to the group and time for increasing acquaintanceships over tea. Following this the members broke up into

groups for a "buzz session" designed to discuss possible topics around which to build the year's program. The result of these "buzz sessions" showed that the majority desired that meetings should be centred around the topic "Student Evaluation." Programs are in process of preparation.

MONTREAL

Royal Victoria Hospital

At the annual meeting of the Saint John, N.B., chapter in October, June (Power) Clarke was elected president and Ruth (Johnson) Trueman, secretary. A. Gilbert is with the V.O.N. in Newcastle, N.B. P. (Walker) Richmond is with the Elgin-St. Thomas Health Unit, London, Ont. H. Rose and E. Mayhew are enrolled in the public health course at University of Western Ontario. W. Kinsman is on the staff of Roseway Hospital, Shelbourne, N.S. P. Lawley is on the staff of the Prince County Hospital, Summerside, P.E.I. J.C. MacGregor was a recent visitor, as well as J. Delmott who is on furlough from WHO in Indo-China.

QUEBEC

Jeffery Hale's Hospital

Miss J. Golden was elected chairman of District No. 9 A.N.P.Q. at the October meeting. She is replacing Miss Joyce Radley Walters. Miss A. Eccles has joined the staff of the Montreal Children's Hospital.

SHERBROOKE

A meeting of the English chapter was held in the Norton Residence of Sherbrooke Hospital in October, 1956. Miss C. Aitkenhead, president, chaired the business meeting. Miss A. Bertram, secretary, is spending some time in Europe, and Miss D. Mewse was chosen to replace her. Suggestions were made for raising money for the Frances E. Upton Fund. Miss L. Henshaw and Miss D. Mewse were chosen as delegates to the interim meeting of the A.N.P.Q. which was held in Montreal. Following the business meeting Miss G. Norris, gave a very interesting outline of the Biennial CNA convention in Winnipeg, illustrated by colored slides.

Sherbrooke Hospital

The October meeting of the staff association was held in the Norton Residence. Miss T. Gratham, president, conducted a short business meeting and discussion, after which colored slides of Bermuda were shown by Miss A. MacElrea, who has spent some time there.

The alumnae association held their October meeting in the Norton Residence with the president Mrs. L. Lebrun in the chair. Plans were made for the fall annual nurses' dance at the New Sherbrooke Hotel, and a Rummage Sale at the McKinnon Memorial.

Employment Opportunities

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Closing date for copy and cancellations: 10th of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Director of Nurses for 120-bed hospital opened 1953. Duties commence February 1, 1957. Must have had experience in similar sized hospital. Apply stating age, qualifications, preparation & experience to Administrator, Penticton Hospital, Penticton, B.C.

Hospital Superintendent & Director of Nurses (Combined) for 35-bed hospital fully accreditted. Good salary. Excellent living quarters. Apply stating references & experience to Chairman, Board of Directors, Fishermen's Memorial Hospital, Box 600, Lunenburg, N.S.

Superintendent for 60-bed hospital with an additional 40-bed wing under construction. Present salary: $290 per mo. with full maintenance. Apply C. F. Chapman, Sec. of Board, Alexandra Marine & General Hospital, Goderich, Ontario.

Superintendent (Registered Nurse) for 17-bed hospital located in the south-eastern part of Saskatchewan. Good train & bus connections to larger Saskatchewan centers & U.S.A. Salary: $280 gross plus semi-annual increments for 2 yrs. 48-hr. wk. Living-in accommodation available. Apply Mr. Ivan Antonichuk, Manager, Bienfait Coalfields Union Hospital, Bienfait, Sask.

Matron for 23-bed hospital (Immediately). Salary: $270-$295. We have 2 doctors & full complement of nurses. Good farming area. Green Water Lake summer resort nearby. Please state experience & apply P. Tomyn, Sec.-Manager, Union Hospital, Kelvington, Sask.

Matron for 20-bed hospital. 2-wk. vacation. 2-wk. sick leave. Residence on grounds. Apply stating salary required to the Matron, Union Hospital, Vanguard, Saskatchewan.

Director of Nursing for 185-bed JCAH accredited General Hospital. Protestant Church affiliated. NLN temporary accredited school of nursing, 75 students. Addition to hospital under construction. Must have B.S. degree in nursing & preferably an M.A. in nursing. Good salary, furnished apt., position open early winter. Apply Administrator, Evangelical Deaconess Hospital, 3245 E. Jefferson Ave., Detroit 7, Michigan.

Associate Director of Nursing Service for 175-bed hospital & school of nursing. New 291-bed hospital to be opened early this year. Excellent personnel policies. Salary open for this position. Apply Director of Nursing General Hospital, Medicine Hat, Alberta.

Supervisor of Nursing (R.N. experienced in nursing service administration desirable) for new modern 50-bed General Hospital in progressive town (10,000) in Cariboo Dist. central B.C., 14 R.N.'s., 10 Aides, 6 Med. staff. Priv. suite in new residence. Salary commensurate with qualifications. 40-hr. wk., 28 days vacation plus 10 statutory holidays Sick leave. Travel allowance. Please state age, salary expected, experience & references to Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C

Supervisor, starting salary: $255. Must be registered in British Columbia. **Operating Room Nurses,** salary: $230 plus $10 'on call.' $10 postgraduate. **Charge Nurses,** salary: $245. **General Duty Nurses,** salary $230. Additional salary paid to nurses with 2 yrs. past experience, plus 4 annual increments to $40. 28 days vacation, 10 statutory holidays. 1½ days sick leave, cumulative. Room rent at nurses' residence $20 per mo. Apply Director of Nursing, Trail-Tadanac Hospital, Trail, B.C.

Supervisor (1), Registered General Duty Nurses (2), Operating Room Nurse (1), immediately for 40-bed hospital in the Annapolis Valley, N.S. Apply Superintendent, Western Kings Memorial Hospital, Berwick, N.S.

Operating Room Supervisor for 97-bed hospital. 44-hr. wk. Statutory holidays. Employee benefits. Living accommodation available. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Supervisors & Staff Nurses. Good salary & personnel policies. Living accommodations available. Apply Director of Nurses, General Hospital, Parry Sound, Ontario.

Obstetrical Supervisor & **General Duty Nurses** for 100-bed modern hospital in south western Ontario — 32 miles from London. Apply giving full particulars of experience to the Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

Night Supervisor, Assistant Head Nurses & Staff Nurses. Excellent personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Que.

Supervisor, starting salary: $245 (must be registered in Sask.). **Charge Nurses,** starting salary: $235. **General Duty Nurses,** salary: $220. 6 increments of $5.00 per mo. every 6 mo. 28-day vacation plus 9 statutory holidays. Full maintenance, $30 per mo. if desired. Apply Director of Nursing, Victoria Hospital, Prince Albert, Sask.

Assistant Evening & Night Supervisors for Children's Hospital. Commencing salary: $240. Apply Director of Nursing, Children's Hospital, Winnipeg, Manitoba.

Science Instructor for 200-bed General Hospital. School of Nursing, September classes only. 40-hr. wk., 1 mo. annual vacation, 10 statutory holidays. 1½ days sick leave per mo. cumulative. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Clinical Instructor for 50-student school of nursing. New Nurses' residence combined with teaching unit. For further information apply to Director, School of Nursing, Victoria Hospital, Winnipeg, Manitoba.

Clinical Instructor & Operating Room Nurse for 75-bed hospital with small school of nursing. Apply to Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

Instructor for school of nursing — Applications are invited for 138-bed hospital. This school is affiliated with Montreal hospitals, the teaching schools associated with McGill University. For particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Instructors (Medical-Surgical Nursing), Assistant Clinical Instructors. B.S. degree required. 5-day wk. 4-wk. vacation, 6½ holidays. 2-wk. sick leave, social security & group insurance. Apply Director of Nurses, Borgess Hospital, Kalamazoo, Michigan.

Assistant Head Nurses & General Duty Nurses for 150-bed Communicable Disease Hospital. Apply Director of Nursing, Alexandra Hospital, Montreal, Que.

Registered General Duty Nurses (2) for modern 35-bed hospital 80 mi. east of Edmonton. Salary: $217.50 less $25 maintenance. 4 semi-annual increases of $5.00. 44-hr. wk. 1 mo. vacation with pay after 1 yr. service. Sick leave benefits. Apply Mrs. S. Brower, Matron, Municipal Hospital, Viking, Alta.

Registered General Duty Nurses for active 50-bed hospital. Salary: $220 plus perquisites. With experience, $225. $5.00 raise every 6 mo. to $240. 1 mo. vacation with pay after 1 yr. service. Usual sick time. **Certified Aides.** Salary: $125 per mo. plus perquisites. $5.00 raise after 6 mo. to $145. 1 mo. vacation after 1 yr. service. For further information apply Matron, Municipal Hospital, Wainwright, Alberta.

Registered Nurses (2) for new 30-bed hospital. Apply Matron, Creston Valley Hospital, Creston, British Columbia.

Registered General Duty Nurses for new 50-bed General Hospital in active B.C. center. Starting salary: $235. 40-hr. wk. 28 days vacation, 10 statutory holidays. Sick leave, full benefits. Travel refund. Private accommodation in new nurses' residence. Offers convivial, harmonious atmosphere. Please state age, qualifications, references. Apply Administrator, G. R. Baker Memorial Hospital, Quesnel, B.C.

Registered Nurse for 36-bed hospital. Starting salary: $205 per mo. Blue Cross benefits, sick leave etc. Apply Superintendent of Nurses, Hospital District No. 24, Box 330, Altona, Manitoba.

Registered Nurse for 8-bed hospital. Duties to commence as soon as possible. Salary: $190 per mo. Full maintenance & uniforms laundered. Modern residence. 1 mo. vacation with pay after 1 yr. service. Annual increment of $5.00 per mo. 2-wk annual sick leave accumulative. Daily train or bus to & from Winnipeg. Apply Matron, Mrs. L. Adams, Reston Unit Hospital, Reston, Manitoba.

Registered Nurses or Graduate Nurses (2) for fully modern 30-bed hospital. Gross starting salary: $210 & $200 per mo. respectively less $25 for full maintenance. Salary increased according to experience. Overtime. $5.00 increment after each 6-mo. service. 44-hr. wk. 4-wk. vacation with pay after 1 yr. service. All statutory holidays. Accumulative sick leave. Separate living quarters. Apply Supt., District Hospital, Roblin, Manitoba.

Registred Nurses for **Matron** & **General Duty** for 14-bed hospital. 8-hr. day. 1 mo. annual vacation. For further information apply Board of Directors, Grand Manan Hospital, Grand Manan, New Brunswick.

Registered Nurse for 40-bed northern hospital. Experienced in X-ray, laboratory & operating rooms & to act as assistant to Matron. For complete information write Matron, Yellowknife District Hospital, Yellowknife, N.W.T.

Registered Nurses. Salary: $225 per mo. gross. 5-day wk. Single room residence. 20 miles east of Toronto. Apply Supt., Ajax & Pickering General Hosp., Ajax, Ont.

Registered Nurses. Gross salary for nurses currently registered in Ont. $235 per mo. Good personnel policies. New facilities. Comfortable nurses' residence. 8-hr. rotating shift. 44-hr. wk. 1 day off 1 wk., 2 the next. 1½ days holiday allowed per mo. same sick time accumulated to 90 days. 8 legal holidays per yr. The equivalent of single train fare paid up to $40 after 1 yr. service. Apply Supt., Lady Minto Hospital, Cochrane, Ont.

McKellar General Hospital, Fort William, Ont., requires **Registered General Duty Nurses.** Good personnel policies. Residence accommodation available at reasonable rates. Hospital has recently completed a well equipped & staffed wing with extensive renovation program progressing in the old section. Apply Director of Nursing.

Registered Nurses for General Duty. Initial salary: $200 per mo.; with 6 or more months Psychiatric experience, $210 per mo. Salary increase at end of 1 yr. 44-hr. wk.; 8 statutory holidays, annual vacation with pay. Living accommodation if desired. For further information apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

Registered General Duty Nurses for 200-bed General Hospital. Salary: $220 per mo. with annual increase. 5½ day wk. Good personnel policies. Apply Director of Nursing, General Hospital, Sault Ste. Marie, Ontario.

Registered General Duty Nurses for County Hospital in Huntingdon, 45 mi. from center of Montreal. Excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. 2 theatres, bowling, curling & dancing. 8 mi. from summer resort on Lake St. Francis & 12 mi. from U.S. border. Gross salary: $200 per mo. Three $5.00 increases at 6-mo. intervals to maximum $215. 44-hr. wk., 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 2-wk. sick leave. Blue Cross paid. 1 mo. annual vacation, all statutory holidays. Apply Mrs. M. G. Curran, R.N., County Hospital, Huntingdon, Que.

Registered Nurses for modern 60-bed General Hospital situated 40 mi. south of Montreal. Salary: $200 per mo., additional monthly bonus for permanent evening & night shifts. 44-hr. wk., 8-hr. duty. Many attractive benefits provided. Board & accommodation available at minimum cost in completely new motel-style nurses' residence. Apply Supt., Barrie Memorial Hospital, Ormstown, Que.

Registered General Duty Nurses for 18-bed active hospital. Good salary. 44-hr. wk. 3-wk. vacation, statutory holidays & sick leave benefits. Apply administrator, District Hospital, Shelburne, Ont.

Staff Nurses for modern 650-bed Tuberculosis Hospital affiliated with Western Reserve University approved by joint commission on accreditation of hospitals. 40-hr., 5-day wk. Beginning salary: $286 with automatic increases. Advancement for eligible applicants. Full maintenance available at minimum rate, housing for 2 or more nurses. Meets approved minimum employment standards of the State Nurses' Association. Apply Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered General Duty Nurses for 118-bed General Hospital along the shores of Lake Michigan, 25 mi. from Chicago. Base salary: $300. Additional differential of $30 for evenings & $20 for nights. 5 day wk. Good personnel policies. Apply Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered Nurses for Medical-Surgical, Psychiatric, Obstetrical & Pediatric Units, 325-bed, air-conditioned hospital. Starting salary: $265 with bonus for evening & night duty. 40-hr. wk. Liberal personnel policies, low cost cafeteria, free laundry. Apply Director of Nursing, Menorah Medical Center, 4949 Rockhill Rd., Kansas City, Missouri.

Registered Nurses for staff nursing in new & beautifully equipped 100-bed hospital in the Pacific northwest. Only 6 mi. from the Pacific Ocean. Delightful climate. Beginning salary: $290 for 40-hr. wk., $10 additional for p.m. & night duty. Apply Director of Nurses, County General Hospital, Tillamook, Oregon.

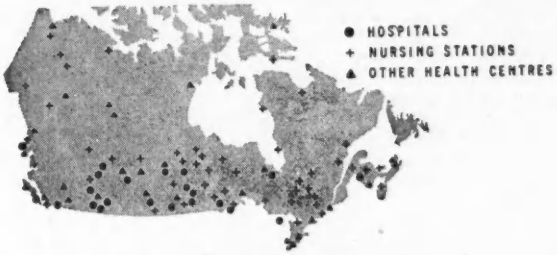
Registered General Duty Nurse in 50-bed hospital in a state institution for children. Could use husband in ward, shop or farm. Beginning salary: $200 plus full maintenance or $250 & live out. 40-hr. wk. plus vacation & sick leave. Good hospital facilities & supervision. Wonderful climate in a mountain setting. Apply State Training School, Lander, Wyoming.

General Duty Nurses, $230-$250, **Operating Room Nurse,** $250-$270 including increments. 40-hr. wk. 28 days vacation & 1½ days sick leave monthly. Room & full board $25 per mo. Fare from Vancouver refunded after 6 mo. service. Apply Matron, St. George's Hospital, Alert Bay, B.C.

General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, 1 mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 430-bed hospital; 40 hr. wk. Statutory holidays. Salary $240-$273. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



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(3) Regional Superintendent, 735 New Federal Building, Regina, Saskatchewan.

(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

General Duty Nurses & trained Nursing Aides (Immediately) for active 800-bed General Hospital with large maternity service. Good working conditions. Salary dependent on experience. Personnel policies sent upon request. For particulars apply Director of Nurses, Royal Alexandra Hospital, Edmonton, Alberta.

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General Duty Nurses for 100-bed hospital in north coast city. Salary: $273 per mo. with 3 yearly increments of $10. Excellent living accommodation $40. Good personnel policies. Apply Supt. of Nurses, Prince Rupert General Hospital, Prince Rupert, B.C.

General Duty Nurse: The Blanchard-Fraser Memorial Hospital (71-bed) located in Kentville, Nova Scotia, offers a General Duty Nurse ideal working conditions. 1 mo. annual vacation, excellent personnel policies plus modern living quarters with full maintenance in new nurses' residence. For further information apply to Superintendent of Nurses.

General Duty Nurses for 65-bed hospital. Gross salary: $185-$210. 44-hr. wk. Statutory holidays. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ont.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses for all departments. Gross salary: $215 per mo. if registered in Ontario, $205 per mo. until registration has been established. $20 per mo. bonus for evening or night duty; annual increment of $10 per mo. for 3 yrs. 44-hr. wk., 8 statutory holidays, 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

General Duty Nurses (2) for new 173-bed hospital. Good personnel policies. Starting salary: $215 per mo. 44-hr. wk. Apply Director of Nurses, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

General Duty Nurses (2) for 20-bed modern hospital. Salary: $255 per mo., less $30 per mo. for full maintenance. Usual holidays with pay, sick leave etc. Fare refunded one way after 1 yr. Separate modern nurses' home. Apply Matron, Union Hospital, Vanguard, Sask.

General Duty Nurses for 650-bed teaching hospital in central California. Salary: $303-$356 per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $300 with 4 annual increases to $341. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Men & Women), for well equipped 400-bed General Hospital. An opportunity to learn nursing team leadership. Monthly salaries: $310-$350 plus differential of $30 monthly for evenings or nights. Attractive individual roms available, $20-$25 per mo. Convenient transportation to colleges & close by famous loop. Write to Dept. CNJ, Mount Sinai Hospital Medical Center, 2750 West, 15th Place, Chicago 8, Illinois.

Staff Nurses for 500-bed General Hospital. Beginning salary: $300 per mo. with advancement to $335 for those eligible for registration in the state of Michigan. Additional differential $1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

General Duty Nurses (Staff positions in all Clinical areas) for 260-bed teaching hospital located half way between Detroit & Chicago. Day duty: $271 per mo. Evening & night duty: $301 per mo. 40-hr. wk. 2-wk. vacation. 2-wk. sick leave. 6½ holidays. Social security & group insurance. Apply Director of Nurses, Borgess Hospital, Kalamazoo, Michigan.

Staff Nurses for 225-bed General Hospital, on outskirts of New York City. Salary: $240-$280. $30 for permanent evening duty, $25 for permanent night duty. Apply Director of Nursing, St. John's Riverside Hospital, Yonkers, N.Y.

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General Staff Nurses for 920-bed General Hospital to open a 250-bed addition in the near future. 40-hr. wk.

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Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

Graduate Nurses (General Staff Positions) for General Hospital. Salary: $239. per mo. as minimum & $277.25 as maximum, plus shift differential for evening & night duty. 40-hr. wk. Temporary residence accommodation is available. Applicants not registered in B.C. should forward a letter of acceptance of registration in B.C. from the Registrar of Nurses, 2524 Cypress St., Vancouver, B.C. Please apply Personnel Dept., Vancouver General Hospital, Vancouver, B.C.

Graduate Nurses (2) for 33-bed General Hospital at Espanola (45 miles from Sudbury). Salary: $215-235 per mo. Blue Cross. Laundry provided. Apply Superintendent, General Hospital, Espanola, Ontario.

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Supervisor (qualified.) Good salary. Extra allowance for experience if French speaking 5-day wk., 4-wk. vacation, 18 days sick leave cumulative annually. Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

Public Health Nurse for generalized program in Alberta East Central Health Unit, Sedgewick sub office. Pension plan. Blue Cross available. For details apply Dr. Donald Mackay, Medical Officer of Health, Stettler, Alberta.

Public Health Nurse Grade I. British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

Public Health Nurse (Qualified) for generalized program including bedside nursing. Salary: $3,000-$3,600. Annual increment $150. Car provided or car allowance. Vacancy January 1st at Brighton office. Apply to Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

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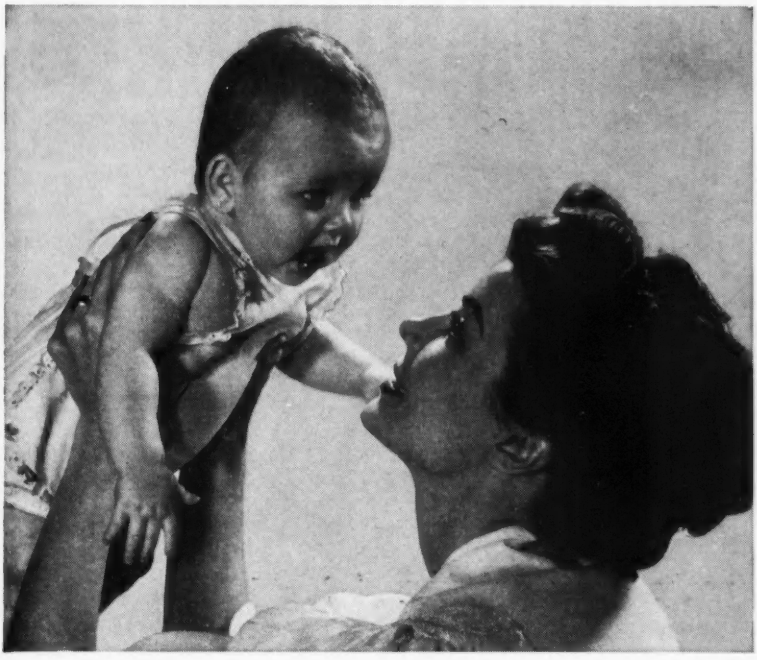

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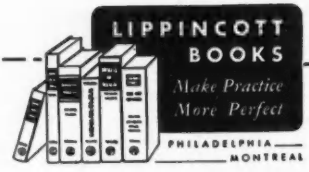

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